Authorization to Release Medical Information to North Park University's Health Services

I, ____ authorize the health care
(Print name and ID#)

providers at Swedish Covenant Medical Group or Swedish Covenant Immediate Care

to release the progress notes as well as any results from tests conducted in support

of this medical visit on _______________ to North Park University's Health Services.
(Date)

I understand that with a few exceptions, records and/or information about myself possessed by health care providers or North Park University cannot be obtained or released unless I agree to the request. I also understand that I do not have to provide my consent at this time. The consent I provide today only applies to this medical visit with Swedish Covenant Medical Group or Swedish Covenant Immediate Care Centers and does not apply to future visits. With few exceptions, this information may not be re-disclosed legally by the recipient unless I give separate, written permission.

_______________________________________ ____________________
Signature of North Park student Date

_______________________________________ ____________________
Signature of witness from Swedish Covenant Date

Updated: 9/2017

Please fax progress note and test results back to NPU Health Services at 773-634-4060