RELEASE OF INFORMATION
BETWEEN HOME HEALTHCARE PROVIDER AND
MESSIAH UNIVERSITY ENGLE CENTER

Date _________________________

This is to certify that I, _________________________________, give full permission to
(Name of student)

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(Name, phone #, FAX # of healthcare provider)

to release to and receive from Messiah University Engle Center:

All information related to my return from medical leave.

This release is effective for one (1) year unless an exception is noted here:_________________

Permission may be revoked by me at any time I choose, by providing notice of the revocation in writing, except to the extent that the person who is to make the disclosure or the person receiving information has already acted upon it.

SIGNATURE OF STUDENT ____

WITNESS ____
(Someone who observes you signing this form)

A copy of this form may be faxed to the Messiah University Engle Center at 717.691.2344, Attn: Medical Leave, or mailed to: Director of Counseling and Health Services, Messiah University, One University Avenue Suite 3028, Mechanicsburg, PA 17055