

Form B

**RELEASE OF INFORMATION
FROM HOME HEALTHCARE PROVIDER TO
MESSIAH COLLEGE ENGLE CENTER**

Date _____

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

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

to release the following information to Messiah College Engle Center:

All relevant information.

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

Permission can be revoked by me at anytime 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 College Engle Center at 717.796.5372, Attn: Ellie Addleman, or mailed to: Ellie Addleman, M.S., NCC, LPC, Director of Counseling and Health Services, Messiah College, One College Avenue Suite 3028, Mechanicsburg, PA 17055