

I the undersigned, do hereby authorize the University Health Center at the University of Pittsburgh at Greensburg to release my medical records concerning any/or all of my treatment received in the University Health Center to the following:

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Patient's Signature: \_\_\_\_\_

Patient's Printed Name: \_\_\_\_\_

Date signed: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Witness Printed Name: \_\_\_\_\_

Date signed: \_\_\_\_\_

Date released from Health Center: \_\_\_\_\_ By whom: \_\_\_\_\_