

I, the undersigned, do hereby authorize _____

To release medical records regarding my past medical history and treatments to:

Patricia LaMantia RN, BC, MSN
University of Pittsburgh at Greensburg
216 Chambers Hall
1150 Mt. Pleasant Road
Greensburg, PA 15601
Fax # 724-836-7907

Students/Patients Signature _____

Students/Patient please print name _____

Date: _____ Last 4 Numbers Social Security _____

Witness _____