Authorization for Release of Immunization Record/University Medical Form

Chaminade University of Honolulu
Office of the Dean of Students
3140 Waialae Avenue, Henry Hall Room 221, Honolulu, HI 96816
Phone: (808) 735-4710 or stari.nakano@chaminade.edu

INSTRUCTIONS: Please complete this Authorization in its entirety. Completed for may be returned via U.S. Mail, email to above address, or dropped off to Office of the Dean of Students. Signature on form must be actual signature (no e-signatures accepted at this time). ***It may take up to ten (10) business days for information to be released.***

Student Name: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____ Chaminade ID Number: _____
Current status: ____ Undergraduate ____ Online ____ Graduate

IMMUNIZATION RECORD/UNIVERSITY MEDICAL FORM RELEASED TO:

Individual/Organization: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____ Fax #: _____ Email: _____

PURPOSE OF REQUEST:
____ Personal ____ Send copy to Chaminade University Athletics ____ School Transfer
____ Other (specify): _____

METHOD OF DELIVERY (Check One):
____ By US Mail ____ Pick up by student in Henry Hall Room 221. ***A current, valid photo ID is required to pick up records.***
____ Electronic Delivery via CUH email
Email Address: _____

INFORMATION REQUESTED:
____ Copy of MMR Vaccination Record ____ Copy of TB Test Results ____ Copy of Health Insurance Card/Information
____ Complete Immunization Record/University Medical Form

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND INITIAL NEXT TO EACH ONE:
____ Authorization of release pertains only to the above specified information and to the above specified parties. I understand that I may revoke this authorization at any time in writing and the authorization will remain valid until revoked or upon expiration of one year from the date of this signed release.

____ I understand that medical information disclosed through this authorization may no longer be protected by federal health information privacy laws and that this information, once disclosed, may be re-disclosed outside the privacy rule.

____ I understand that this authorization is voluntary and I may refuse to sign it. The immediate consequences of my refusal will be that Chaminade University of Honolulu Office of the Dean of Students will not release the medical information listed above through this authorization. I understand my treatment, payment, or enrollment, will not be conditioned on whether I sign this authorization.

____ I understand the release of medical information may take up to 10 (ten) business days to be processed.

Student Signature: _____ Date: _____

Signature Parent/Guardian (if under age 18): _____ Date: _____