

SMITH COLLEGE HEALTH SERVICES

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Smith College Health Services to disclose my health information as described below. I understand that this authorization is voluntary. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the federal privacy regulations.

1. Patient-Student name: _____ 2. Date of Birth _____

3. Person(s) receiving my health information [Example: "My employer"]:

Name: _____

Address: _____

4. Description of records or information being disclosed: _____

5. Purpose of the Disclosure [Example: "At the request of the patient"]:

Expiration

1 year from the date in which I, or my legal representative, signs this authorization;

upon the happening of the following event: _____
_____ [Example: "Upon release of the above records"].

Right to Revoke: I understand that I may revoke this authorization at any time by providing written notice to the Smith College Health Services at the address shown above. I understand that my revocation will not have any affect on any actions taken before the receipt of the revocation.

I understand that Smith College will not condition my treatment, enrollment in a health plan, or eligibility for benefits on my signing this authorization. I further release Smith College, its trustees, employees and agents from all liability or legal responsibility arising from the disclosure of these records or information.

Signature of Patient or Legal Representative Yr. Of Graduation Today's date

If signed by the patient's legal representative:

Printed Name of representative: _____

Relationship to the patient: _____

**THERE IS A \$10 FEE FOR COPYING THE ENTIRE MEDICAL CHART. PLEASE
MAKE CHECK OUT TO SMITH COLLEGE HEALTH SERVICES.-**

PROVIDE COPY TO THE PATIENT AND MAINTAIN A COPY IN THE PATIENT'S RECORD -