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: ____

Fax: ____

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.")

<u>Right to Revoke</u>: 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 Year of Graduation Date

If signed by the patient's legal representative:

Printed name of representative: ____

Relationship to the patient: ____

If we should need to contact you, please provide your telephone number and/or email address below:

Telephone: ______________________________ Email: ___________________________________

THERE IS A $10 FEE FOR COPYING THE <u>ENTIRE</u> MEDICAL CHART.

PLEASE MAKE CHECK PAYABLE TO SMITH COLLEGE HEALTH SERVICES.

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

November 2013