Smith College Schacht Center for Health and Wellness
21 Belmont Avenue, Northampton, MA 01063; Phone: (413) 585-2800 Fax: (413) 585-4639

Authorization for Release of Information

Legal Name: ______________________________________ Name: ____________________ DOB: ____________________

Section 1: Health & Personal Information to be Shared

A. **Health & Personal Information:** Please describe the type of information that you want to share.
☐ Medical Information ☐ Mental Health Information ☐ Phone or Email Communication ☐ Other:
____
____

B. **Permission Regarding Specific Health Information:** Some types of health information carry more specific protections. If you explicitly choose to share any of the information listed below, please write your initials on the line (otherwise these will not be included, even with the release of "all records", per state law):

_____ I specifically give permission to share information in my record about HIV antibody and antigen testing, and HIV/AIDs diagnosis or treatment.

_____ I specifically give permission to share information in my record about genetic information.

_____ I specifically give permission to share information about substance use.

Section 2: Who May Share or Receive This Information:

Schacht Center may: ☐ Share information ☐ Receive information ☐ Share & Receive Information
with: ☐ Class Deans ☐ ODS ☐ Student Affairs ☐ Athletics ☐ Dining
☐ Other (If other, please specify): ____

Name/Organization: ____

Address: ____

Phone: ____________________________ Fax: _______________________ Email:____________________________

Section 3: How Long Permission to Share Information Lasts:

☐ This permission will last until I graduate from Smith College.
☐ This permission will last for one year from the date it is signed.
☐ This permission will last until the following specified date (indicate date): _____________________

Section 4: Student/Patient Rights

Right to Decline Sharing Information: My signature below confirms my understanding that I do not have to give permission to share my information with any person(s) or organization.

Right to Revoke Permission: My signature below confirms my understanding that I may revoke this authorization at any time by providing written notice. I further understand that my revocation will not have any effect on any actions taken before the receipt of the revocation.

Patient Protections: 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 Anticipated Year of Graduation Date

If signed by patient's legal representative: Printed name of representative: ___________________________________
Relationship to patient: ____