

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the Schacht Center for Health and Wellness 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.

Patient-Student Name: _____ Date of Birth: _____

ID# _____ Email: _____ Phone #: _____

Release Records To:

Name: _____

Address: _____

Preferred Method of Delivery (please check all that apply):

US Mail (to address above) Fax: _____ Email: _____

Release the following:

Entire Medical Record (\$10 fee) Immunization Record Only Laboratory Reports

Other (indicate specific portions of medical record needed): _____

I agree to the release of: HIV testing records Alcohol/drug treatment records

Expiration:

Upon the release of the above records

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

Right to Revoke: I understand that I may revoke this authorization at any time by providing written notice to the Schacht Center for Health and Wellness at the address shown above. I understand that my revocation will not have any effect 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: _____

There is a \$10 Fee for copying the Entire Medical Report. Please make check payable to: Smith College Medical Services

Please Note: Depending on the size of the record, faxing/email may not be an option.

~Provider copy to the patient and maintain a copy in the patient's record~