Mount Holyoke College Health Services

50 College St., Pattie Groves Health Center

South Hadley, MA 01075

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[health-admin@mtholyoke.edu](mailto:health-admin@mtholyoke.edu)

Authorization to Release or Obtain Medical Records

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cell / home / work

I hereby authorize **Mount Holyoke College Health Services** to:

**Release** information **to**:  **Obtain** information **from**:

Name of Person, Provider, Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Method of communication* (check all that apply)  Fax  Email  Mail  Talk to (on phone/in person)

For the **purposes** of:

Continuing care  Transferring to new provider  Personal use  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

From the **following dates of care**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization expires on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (if blank, authorization expires 180 days from date below)

Information to be **disclosed:**

Entire Medical Record  Immunization Records  Laboratory Reports  Radiology Results

Pathology Reports  Office Visit Notes  Operative/Procedure Report  Mental Health

Other (specify portions of medical record requested):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Disclosures Requiring Special Consent** (Complete this section for release of specific privileged information)

\_\_\_\_\_\_\_(initial) ALCOHOL AND DRUG TREATMENT/SENSITIVE INFORMATION: I understand that my record may contain information in reference to treatment for substance and/or alcohol abuse, psychiatric treatment, sexually transmitted diseases, social service notes, or other sensitive information. I agree to its release unless specified otherwise (please explain limitations) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ (initial) HIV/AIDS: I understand that my medical record may contain information relating to HIV (AIDS) testing or treatment and I agree to its release.

I understand that I have the right to revoke this authorization, except to the extent that action has already been taken, in writing at any time. Information disclosed under this authorization might be re-disclosed by the recipient, except disclosures requiring special consent, and this re-disclosure may no longer be protected by federal or state law.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Patient’s Representative Date