MOUNT HOLYOKE COLLEGE

College Health Services

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

NAME: _____ DATE OF BIRTH: _____

PHONE #: _____

I hereby authorize and request Mount Holyoke College Health Services staff to disclose the information specified below:

- Send Medical Records (office notes, labs, diagnostic tests)
- Request Records _____
- Authorize Phone discussion / E-mail correspondence

For: Dates of treatment: _____ to _____

Condition: _____

Please release the authorized information to: (*initial those that apply*)

_____ MHC Counseling Service _____ Athletics

_____ Office of the Academic Deans _____ Disability Services

_____ Parent/Guardian: _____Phone:_____

E-mail:_____

_____ Other: _____

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These records may contain information about drug abuse, alcoholism, AIDS, alcohol abuse, sexually transmitted disease, abortion or sexual abuse.

I Do DO NOT (circle one) consent to have this information disclosed.

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a six-month period from the date that it is signed.

_____ Date: _____

Signature

_____ Expires: _____

Witness