

Hobart and William Smith Colleges

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

NAME _____ DOB _____ PHONE _____
ADDRESS _____

Please request/check all that apply:

I, _____ do hereby consent to and authorize Hubbs Health Center, Hobart & William Smith Colleges to release or obtain the following medical information to the part(ies) listed below:

Emergency Room visit on _____ Hospitalization on _____ to _____

Ambulatory Surgery on _____

Specialty (Pap Smear results, other lab tests, operative reports) _____
(Date performed)

Complete Record Immunization Record Last Physical Exam Patient Health Summary

Medication List Other _____ (specify)

I understand that this Authorization may include disclosures of information relating to alcohol and drug abuse and mental health treatment (except psychotherapy notes) only if I place my initials on the appropriate line below. If I am authorizing the release of alcohol or drug treatment or mental health information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.

Include: (*Indicate by Initialing*)

_____ Alcohol/Drug Treatment

_____ Mental Health Information

Confidential HIV related information cannot be disclosed pursuant to this Authorization. A separate Authorization form must be used, which is available at the Hubbs Health Center.

The Records are to be released or obtained: Health Care Provider Parents Other
(Specify below) (Specify below) (Specify below)

Name _____

Address _____

Phone _____ Fax _____

Reason for disclosure: Patient Request Other _____
(over)

I understand that signing this Authorization is voluntary and that my treatment or service is not conditioned on whether I sign this Authorization. If I choose not to sign this Authorization, my medical information will not be shared without my written consent.

I have the right to revoke this Authorization at any time by writing to Hubbs Health Center. I understand that I may revoke this Authorization except to the extent that action has already been taken based on this Authorization prior to its revocation.

I understand that information disclosed under this Authorization might be redisclosed by the recipient (subject to applicable legal restrictions), and this redisclosure may no longer be protected by federal or state law.

This Authorization expires one year from today or on such other date as specified below:

_____ .

If not the Patient, name
of person signing this
Authorization: _____

Authority to sign
on behalf of
Patient: _____

Patient's (or
Representative's) Name
(print) _____

Patient's (or
Representative's)
Signature _____

Address _____

Date _____

Witness _____