

BOWDOIN COLLEGE

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I, _____, authorize _____ its
(Patient) (Sending Provider)

Employees and agents to disclose and discuss my Health Care Information Records relating to

_____ with _____.
(Patient's reason for seeking medical services) (Receiving Individual or Entity)

Please forward:

- All of my treatment record information, including history, dates, course and summary of treatment received here.
 Treatment records on file from other health care practitioners.
 Statements I have added to my treatment records, with responses, if any.
 Only _____
 Any care relating to _____ during the period for which this release is effective.

This information may be used for:

- Ongoing treatment/after care.
 Other _____

I DO DO NOT authorize the release of any information relating to the diagnosis or treatment of ALCOHOL OR DRUG ABUSE under this authorization. If I authorize the release of this information, I understand that such information cannot be re-disclosed by a recipient without my specific consent.

I DO DO NOT authorize the release of any information relating to the diagnosis or treatment of MENTAL HEALTH under this authorization. If I authorize the release of this information, I DO DO NOT want to review this information before it is released. I understand that any such review must be supervised.

I DO DO NOT authorize the release of any information relating to my HIV infection status information under this authorization. I acknowledge by my signature below that I have been advised of the potential implication of authorizing the release of HIV infection status information.

My consent to release these records is effective until _____, and I authorize future disclosures regarding these records to the same individuals or entities during this time period.

I understand that:

- I can revoke all or part of this authorization at any time by notifying the facility in writing, or orally, subject to the rights of anyone who receive or disclose information prior to receiving my revocation.
I can refuse to disclose all or some of the information in my treatment records.
A refusal or revocation to disclose all or some of the information may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences.
I can have a copy of this form upon request.
I can cross out any provision on this form with which I disagree.

Bowdoin College Health Services, 3600 College Station, Brunswick, ME 04011
Telephone: (207)-725-3770 Fax: (207)-725-3905

Signed: _____ Date: _____
(Patient or his/her legally appointed representative)

DOB: _____ SS#: _____