# AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

**BOWDOIN COLLEGE HEALTH SERVICES**
**3600 College Station, Brunswick, ME 04011**
**Telephone: 207.725.3770 Fax: 207.725.3905**

I, _____, authorize _____ its employees and agents, to disclose and/or discuss my Health Care Information with:

Facility/Name:_____ Address: _____

City/State/Zip Code: _____ and/or Fax: _____

**Information to be released and/or discussed:**

- ☐ A summary of my care including:
  - Patient Summary (continuing problems, medical history, surgical history, social history, vital signs, allergies, intolerances, current medications, preferred pharmacies, visit summaries)
  - Immunization Records
  - Diagnostic Tests
- ☐ Any care relating to _____during the period for which this release is effective
- ☐ Statements I have added to my treatment records, with responses, if any
- ☐ Only _____
- ☐ 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.

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

DOB: _____ Class Year: _____