AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH INFORMATION

Regarding Patient (see reverse side for additional information)

Legal Name: -Last, First, MI		Date of Birth:
Street Address:		Bowdoin ID#
City:	State:	Zip Code:

1. **Information Released To ☐ From ☐**

Name: Bowdoin Health and Counseling Services and Treating Provider(s) (if desired)		
Street Address: 3600 College Station		
City: Brunswick	State: ME	Zip Code: 04011
Phone #: 207.725.3770	Fax#: 207.725.3515	
Email: healthservices@bowdoin.edu ;		

2. **Information Released To ☐ From ☐**

Within Bowdoin College:

❑ Dean's office	❑ Wellness Coach
❑ Registrar/Recording Committee	❑ Risk Management
❑ Professor	❑ Director of Student Accessibility
❑ Dietician	❑ Eating Disorder Team
❑ Athletics (Coach, Trainer)	❑ CARE team

Outside of Bowdoin College:

Name (Individual or Class of Individuals at a particular entity, Lawyer, Parent, etc.):		
Street Address:		
City:	State:	Zip:
Phone #:	Fax#:	Email:

3. By initialing here I permit the parties listed in #1 and #2 to share my confidential health information with each other (bidirectionally) _____

4. **Information to be released:**

❑ Complete Copy of Records	❑ Radiology Reports	Specific information pertaining to:
❑ Immunizations	❑ Procedures	❑ Concussion
❑ Laboratory Results	❑ Office Visits	❑ Mononucleosis Infection
❑ Medication List	❑	❑

Federal and State laws require special permission to release the following certain information. Check below to authorize release of:

❑ Mental Health	❑ Substance Use	❑ HIV/AIDS

5. **Purpose of disclosure:**

❑ Coordination of care	❑ Transfer of Care	❑ Academics	❑ Other

6. **Form of Disclosure or Communication**

❑ Verbal (phone or in-person)	❑ Email	❑ Fax

7. This authorization is effective for one (1) year from this date unless otherwise specified here:_____. I authorize future disclosures regarding these records to the same individuals or entities during this time, in accordance with this Release. By signing below, I authorize release of my health records in accordance with the specifications listed above.

Signature of Patient/Representative _____ **Date** _____

***Note to Recipient of Information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorizations, laws may prohibit you from making further disclosures of this information without the specific consent of the patient or legal representative involved.**