

**Release of Information**

I \_\_\_\_\_ hereby authorize and request that the providers  
**Print Name Used at Time of Service**  
listed below be permitted to verbally communicate, send, and/or receive medical  
information obtained in the course of treatment of myself relating to:

\_\_\_\_\_ **Dates of service and/or reason for services**

<b>From:</b> Name _____	<b>To:</b> Name _____
Address _____	Address _____
Fax _____ Phone _____	Fax _____ Phone _____

**Please release the following:**

\_\_\_ All of my medical information regarding the above dates of service and/or reasons for services.

\_\_\_ Only the following portions of my medical record:

- \_\_\_ History and Physical    \_\_\_ Immunization Records
- \_\_\_ Lab Results regarding above dates of service and/or reasons for services.
- \_\_\_ Medical Notes regarding above dates of service and/or reasons for services.
- \_\_\_ Medical records received from other healthcare providers/facilities.
- \_\_\_ Treatment Plan
- \_\_\_ Psychological Testing    \_\_\_ Psychiatric Evaluation and Treatment Plan
- \_\_\_ Other (specify) \_\_\_\_\_

(For Alcohol and Drug Abuse Treatment Records, please use designated authorization form.)

**I understand:**

This authorization is voluntary. I may revoke all or part of this authorization at any time by notifying the Bates College Health Center in writing subject to the rights of anyone who received or disclosed information prior to receiving my revocation. This revocation will be signed and dated by me and will be retained as part of my medical record.

This written authorization must be retained in my medical record. I may have a copy of this release of information form upon request.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Printed Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Class(Year)** \_\_\_\_\_ **Witness Signature** \_\_\_\_\_

9/04