

**Bates College Health Center
Release of Information**

I _____ hereby authorize and request that the providers listed
Print Name Used at Time of Service
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

To: _____ From: _____
Name _____ Name _____

Address _____ Address _____

Fax _____ Phone _____ Fax _____ Phone _____

Please release the following:

- ____ All of my medical information generated by Bates College Health Center 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 service.
 - ____ Medical records received from other healthcare providers/facilities.
 - ____ Treatment Plan
 - ____ Psychological Testing
 - ____ Psychiatric Evaluation and Treatment Plan
 - ____ Other (specify) _____
 - ____ HIV testing
 - ____ Sexual Health

(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** _____
Witness Signature _____