HAMPSHIRE COLLEGE HEALTH AND COUNSELING SERVICES
893 WEST STREET AMHERST, MA 01002
PHONE (413) 559-5458
FAX (413) 559-5583

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

When completed and signed by you, this form authorizes release of protected information from your clinical record to the recipient designated.

Name: _____ Date of Birth: _____

Address: _____ Student I.D. #: _____

_____ Phone: _____

RELEASE OF INFORMATION SPECIFIED TO:

Name: Hampshire College Athletics Staff and Coaches

Street: 893 West Street

City, State, Zip: Amherst, MA 01002

RELEASE THE FOLLOWING INFORMATION:

Documentation of clearance status from my MOST RECENT Sports Physical (be that from a HCS provider or from my home medical provider)

I REQUEST THAT THIS PROTECTED INFORMATION BE RELEASED FOR THE FOLLOWING REASONS:

This documentation is required for participation in Hampshire College Athletics.

- This authorization shall remain in effect for six months from the date above.
- I hereby authorize Health Services to disclose my medical information as requested.
- I may revoke this authorization at any time by sending written notification to Health Services at the address on this form.
- I understand that the revocation will not be effective to the extent that action has already been taken on the authorization. There is no cost to send copies of medical records to another provider, or healthcare facility. Copies for personal use, insurance companies, or legal purposes will be charged a fee.

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

(Revised 2021)