AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, birth date _____,
authorize and request:

NAME: _____
STREET: _____
CITY, STATE, ZIP: _____
TEL: _____ FAX: _____

to release to:

Hampshire College Health & Counseling Services
893 West Street
Amherst, MA 01002-3359
Tel: 413-559-5458 Fax: 413-559-5583

the following information:

___ Entire Health Record ___ Immunization Information Only
___ Specific Dates of Treatment: From _____ to _____
___Other: _____

Special Authorization: (Check all that apply below)
By signing below I am authorizing the release of information regarding:
alcohol, ☐ drugs, ☐ mental health, ☐ sexually transmitted illnesses, ☐ HIV, ☐ AIDS, or
or ☐ AIDS related Complex (ARC)
The information released may include: treatment summaries, progress notes, test results, verbal exchange between treating persons or facilities.
Other: _____
I understand that this authorization will automatically expire twelve months from the date signed OR on the following date: _____.
SIGNATURE: _____

I am requesting that this information be released for the following reason:
_____
_____

This authorization shall remain in effect until _____(specify date up to six months) at which time it expires.

SIGNATURE: _____Telephone# _____

DATE: _____ WITNESS: _____

Revised 08/08