Student Name: ________________________________
Student ID #: ________________________________
Grad. Year: ________________________________

GOUCHER | college

STUDENT HEALTH AND
COUNSELING SERVICES

1021 Dulaney Valley Road
Towson, MD 21204
410-337-6050 (Phone)
410-337-6051 (Fax)

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL RECORDS AND INFORMATION

I, the undersigned student or legal representative, hereby authorize _______________________________________
□ to disclose □ to receive □ to exchange
the following information from my records in verbal, electronic and/or written form:

- ❑ History and Physical exam performed on Date:____________________ Time: ________________________
- ❑ Goucher College Student Health Services visit on Date(s)_____________________
- ❑ GYN records, annual GYN exam, PAP, other tests results performed on Date(s)__________________________
- ❑ Lab reports**, x-ray reports, and other test results from Date:_______________ to Date:_____________________
- ❑ Immunization records from Date:_______________ to Date:________________
- ❑ Psychiatric evaluation from Date:_______________
- ❑ Mental Health Records from Date:______________ to Date:________________
- ❑ Verification of treatment
- ❑ Other:____

I am aware that the records released may contain information related to sexually transmitted disease, HIV-status, alcohol/drug use, or mental health. I, specifically, PROHIBIT the release of the following information (SPECIFY):

____INITIAL HERE:_____

Purpose of disclosure of information (check all that apply):

- ❑ At patient's request
- ❑ Continuing care
- ❑ Verification of services provided for insurance payment purposes
- ❑ Other:____

Person/institution to whom information is to be disclosed:

- ❑ Self
- ❑ Goucher College Student Health & Counseling Staff:____
- ❑ Goucher College Administration/Faculty/Staff: ____
- ❑ Non-Goucher Recipient: ____

  Address:____

  Phone/Fax: ____

Expiration Date of Authorization (may not exceed one year): ______________

Student Signature ____ Date: ____________________

Signature of Legal Representative (if applicable):_______________________ Describe authority to act for the student:___________________

You may revoke this authorization at any time, by writing to Director, Goucher College Student Health and Counseling Services. The revocation will become effective on date received by Director. The recipient of information covered in this release may not make any further disclosure of the information without specific consent of the student or his/her legal representative or as otherwise provided by law.

Version 5/2012