

Goucher College Student Health Services
1021 Dulaney Valley Road
Towson, MD 21204
410-337-6050
410-337-6051 (Fax)

**AUTHORIZATION FOR RELEASE OF ALLERGY SHOT INFORMATION TO
GOUCHER COLLEGE STUDENT HEALTH**

Name: _____ Student ID #: _____
Birth Date: _____ Social Security #: _____

I, _____, hereby authorize _____ to use/disclose:
(Institution/person(s) to release information)

Information to be disclosed:

- Allergy shot records covering the period from: Date _____ to Date _____
- Other: _____

Purpose of disclosure of information:

- At patient's request
- Assist health care providers in care of patient
- Other: _____

Person/institution to whom information is to be disclosed:

Goucher College
Student Health & Counseling Center
1021 Dulaney Valley Road
Baltimore, MD 21204
Fax 410-337-6051

You may revoke this authorization at any time, by writing to Director, Goucher College Student Health Services. The revocation will become effective on the day Goucher College receives it, except to the extent that (a) Goucher College has made a disclosure before the effective date of the revocation; or (b) if the authorization was obtained as a condition of obtaining health insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Individual's Signature _____ Date _____
Witness: _____ Date _____

Signature of Personal Representative if applicable* _____
*Describe authority to act for the patient: _____

Expiration Date (may not exceed one year): _____

HIPAA/Authorization for use/disclosure
jmh/2006