

GOUCHER COLLEGE STUDENT HEALTH SERVICES

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

Student Name: _____
Student ID No: _____
Yr. Graduation: _____

AUTHORIZATION FOR DISCLOSURE OF INFORMATION FROM MEDICAL RECORDS

I hereby authorize _____ to disclose the following information from my health 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, xray reports, and other test results from Date: _____ to Date: _____
- Immunization records from Date: _____ to Date: _____
- Mental Health Records from Date: _____ to Date: _____
- Other: _____

State any limitations on the above disclosures (e.g., release of information relating to drug/alcohol use, mental health treatment, sexually transmitted disease):

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

- At patient's request
- Assist other health care providers in providing me medical care
- Verification of services provided for insurance payment purposes
- Other: _____

Person/institution to whom information is to be disclosed: _____

Address: _____

Phone: _____
Fax: _____

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

Student Signature _____ **Date** _____

Signature of Personal 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 Services. The revocation will become effective on the day Goucher College receives it.

Goucher College Student Health Services will notify the individual/institution to whom this information is provided that the information may not be redisclosed to any person without your written consent.