

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

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: _____