

MOUNT HOLYOKESM

Department of Human Resources
50 College Street
Skinner Hall, Room 1
South Hadley, MA 01075-1453
Telephone: 413-538-2503

RELEASE OF INFORMATION

I, _____, hereby authorize and request the release and delivery of all of my medical records, charts, files, diagnosis, prognoses, reports, x-rays, laboratory reports and such other similar or related information related to my injury or illness designated below to my employer, Mount Holyoke College or their representative.

INJURY OR ILLNESS INVOLVED: _____

This release of medical information is good and valid until or unless rescinded in writing by me, and a copy of this statement and my signature on this statement is as valid as the original.

Date: _____ Signature: _____