MOUNT HOLYOKE | Counseling Service

RECORD RELEASE AUTHORIZATION

Groves Health Center • 50 College Street • South Hadley, MA 01075 • P: 413-538-2037 • F: 413-538-3518

Full Name _____ DOB _____

(include legal name and any former names used while at MHC)

Current Address _____

Street Address City, State/Province, ZIP, Country

Phone _____ Email _____ MHC OneCard ID: _____

Indicate your understanding by placing your initials before each statement:

____ The Mount Holyoke College Counseling Service releases a treatment summary (including, but not limited to: dates and course of treatment, primary providers, diagnosis if applicable, any medications prescribed, plan) in response to requests for records.

____ Additional clinical records are released only to health and/or mental health providers when specifically requested and clinically indicated, and are not released to anyone other than a clinical provider unless otherwise discussed with me and/or approved by a Counseling Service staff member in unique circumstances.

____ Clinical records may contain information about alcohol and/or other substance use, HIV/AIDS, sexually transmitted infections, abortion, sexual and/or physical abuse, or other sensitive information. I agree to the release of this information unless specified otherwise below (please specify any limitations):

_____

____ The Counseling Service is not able to ensure that records shared with parties identified in this release will be held confidential by the recipients.

____ If I am requesting records for my personal reference/review, I understand that reviewing my records may remind me of events I have not thought of in a while and/or I may have questions about the content. It is recommended that I schedule an appointment with my primary clinician (if available) for this review, or, if I prefer, I may request to meet with another clinician for this purpose.

____ Access to any of my clinical records beyond the treatment summary must be specifically requested and will be provided only when not clinically contraindicated. I can make this request by contacting the Counseling Service Student Care Coordinator.

____ The Counseling Service Student Care Coordinator (or designee) may contact me if any additional information or consultation is needed to process my request for records.

Phone number (including area/country code): _____

May we leave a detailed message at this number? ❑ Yes ❑ No

I hereby authorize and request that the:	**Release a treatment summary to:** (you must provide the full name and address of person or organization, including yourself if you are requesting review of your records)
Mount Holyoke College Counseling Service Groves Health Center 50 College Street South Hadley, MA 01075 P: 413-538-2037 F: 413-538-3518	_____ _____ _____ _____

Note: Persons aged eighteen (18) years or older must authorize their own individual record release. If any party other than you gives such consent, their capacity must be specified (e.g., parent, guardian).

SIGNATURE _____ **DATE** _____

PRINT NAME _____