



Mount Holyoke College Health Services
50 College St., Pattie Groves Health Center
South Hadley, MA 01075
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health-admin@mtholyoke.edu

Authorization to Release or Obtain Medical Records

Patient Name: _____ Date of Birth: _____
Address: _____
Phone Number: _____

I hereby authorize **Mount Holyoke College Health Services** to:

☐ **Release** information to:

☐ **Obtain** information from:

Name of Person, Provider, Facility: _____
Address: _____
Phone Number: _____ Fax Number: _____

Method of communication (check all that apply) ☐ Fax ☐ Email ☐ Mail ☐ Talk to (on phone/in person)

For the **purposes** of:

☐ Continuing care ☐ Transferring to new provider ☐ Personal use ☐ Other _____

From the **following dates of care**: _____ to _____

This authorization expires on _____ (if blank, authorization expires 180 days from date below)

Information to be **disclosed**:

- ☐ Entire Medical Record ☐ Immunization Records ☐ Laboratory Reports ☐ Radiology Results
☐ Pathology Reports ☐ Office Visit Notes ☐ Operative/Procedure Report ☐ Mental Health
☐ Other (specify portions of medical record requested): _____

Disclosures Requiring Special Consent (Complete this section for release of specific privileged information)

☐ _____ (initial) ALCOHOL AND DRUG TREATMENT/SENSITIVE INFORMATION: I understand that my record may contain information in reference to treatment for substance and/or alcohol abuse, psychiatric treatment, sexually transmitted diseases, social service notes, or other sensitive information. I agree to its release unless specified otherwise (please explain limitations) _____

☐ _____ (initial) HIV/AIDS: I understand that my medical record may contain information relating to HIV (AIDS) testing or treatment and I agree to its release.

I understand that I have the right to revoke this authorization, except to the extent that action has already been taken, in writing at any time. Information disclosed under this authorization might be re-disclosed by the recipient, except disclosures requiring special consent, and this re-disclosure may no longer be protected by federal or state law.

Signature of Patient or Patient's Representative

Date