Mount Holyoke College Health Services
50 College St., Pattie Groves Health Center
South Hadley, MA 01075
(p) 413-538-2121 (f) 413-538-2352
health-admin@mtholyoke.edu

Authorization to Release or Obtain Medical Records

Patient Name: _____ Date of Birth: _____
Address: _____
Phone Number: _____ cell / home / work

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