MOUNT HOLYOKE

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION
Campus Partners

Name:________________________________ Pronouns: ______________ DOB: ______________

ID#: _____________________ Class Year: _____________ Academic Dean: ___________________

Address: **Mount Holyoke College, 50 College Street, South Hadley, MA 01075**

I hereby authorize **Health Services** to disclose the information specified below

- ☐ Send Medical Records (office notes, labs, diagnostic tests)
- ☐ Request records ________________________________
- ☐ Authorize Phone Discussion / Email correspondence

For: Dates of treatment: ____________________ to ______________

Condition: ____

Please release the authorized information to: *(check those that apply)*

☐ MHC Counseling Service　　☐ Athletics

☐ Office of the Academic Deans　　☐ Disability Services

☐ Parent/guardian: ____

Phone: _____________________ Email: ____

☐ Other: ____

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These records may contain information about substance use, HIV/AIDS, sexually transmitted disease, abortion or sexual abuse.

I Do *consent to have this information disclosed.*

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is ***valid for a six-month period from the date it is signed****.*

Patient Signature: __________________________________ Date: ______________________________

Witness Signature: _________________________________ Witness Name: _______________________