MOUNT HOLYOKE | Counseling Service

RECORD REQUEST AUTHORIZATION

Full Name _____ DOB _____
(include any former names used while at MHC)

Current Address _____
Street Address City, State, ZIP, Country

Class Year _____ Phone _____ Email _____

I hereby authorize and request (print full name and address)

_____

_____

_____

_____

To release the following:

- ❑ Psychotropic medication evaluation/records
- ❑ Copy of most recent Intake
- ❑ Copies of **ALL COUNSELING RECORDS** from _____ to _____
- ❑ Other (state specific portions of record requested):

_____

* I am not giving permission for any redisclosure of this information by the recipient.

Please forward copies of record(s) to:

Mount Holyoke College Counseling Service
Pattie J. Groves Health Center
50 College Street
South Hadley, MA 01075
P: 413-538-2037 F: 413-538-3518

Please initial each statement:

_____ I understand that my record may contain information in reference to treatment for substance and/or alcohol abuse, sexually transmitted infections, abortion, sexual and/or physical abuse, or other sensitive information. I agree to its release unless specified otherwise (please explain limitations):

_____

_____

_____ I understand that my record may contain information relating to HIV (AIDS) testing or treatment, and I agree to its release.

SIGNATURE _____ DATE _____
(Patient or Guardian's Signature)

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