AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize Hood College Health Center located at 401 Rosemont Ave. Frederick, Maryland 21701 (Phone #: (301) 696-3439) (Fax #: 301-696-3442) to:

[ ] disclose information to **[ ] obtain information from** **[ ] exchange information with**

Name or Agency Name: _____

Address: _____
(street) (city) (state) (zip)

Phone #: _____ Email or Fax #:_____

****

Student/Patient Name: _____
(PLEASE PRINT)

Student/Patient Phone #: _____ Student/Patient Date of Birth:_____

Student/Patient Address: _____
(street) (city) (state) (zip)

The information to be disclosed/received/exchanged is:
[ ] Attendance information
[ ] Summary of treatment
[ ] All medical records
[ ] Withdrawal/Readmission recommendation
[ ] Other (please specify):_____
_____

[ ] I also authorize you to speak and disclose orally any information relating to diagnosis, care, treatment, prognosis, opinions, etc. with regard to the above named student/patient.

This Consent is effective for one (1) year from the date below or until: _____

I recognize and understand that the purpose of this authorization and release of this information is at the request of the student/patient. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and any revocation is not effective until received by the Hood College Heath Center or any other entity/agency named above. I understand that any revocation of this authorization will not affect any actions taken in reliance on this authorization before the Hood College Health Center or any other entity/agency received notice of the revocation. I understand that that I may specify a date for the expiration of this authorization, but that it shall expire no later than one year from the date below. I understand that information disclosed under this authorization may be subject to re-disclosure and may no longer be protected by federal or state privacy protections. Unless otherwise notified, I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits.

_____ ____ _____
Student/Patient or Legal Representative's Signature **Date**

Printed Name of Student/Patient's Legal Representative: _____
Relationship or Authority to Act for Student/Patient:_____