

Medical Record Release Form

Colby College
Garrison-Foster Health Center
Phone (207)-859-4460
Fax (207)-859-4475
4460 Mayflower Hill Drive
Waterville, Maine 04901-8844

Name (Please Print) _____ Date of Birth _____

ID # _____ Class Year _____ Phone _____

_____ A. I request that the Colby College Health Service release information to the following Name & address of individual, agency or organization.

to: _____

Purpose: _____

_____ B. I request that information be **released to Colby College Health Service** (address above),

from: _____

Purpose: _____

Describe below portion of record or specific information to be released:

1. I do/do not authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse. _____
2. I do/do not authorize disclosure of information which refers to treatment or diagnosis of psychiatric illness. _____
3. I do/do not authorize disclosure of information which refers to treatment or diagnosis of HIV, AIDS, or STD testing. _____

You have the right to revoke the request, except to the extent the covered entity has taken action by making the request in writing; a revocation such as this may be the basis for denial of health benefits or other insurance coverage or benefits. You may refuse authorization to disclose all or some health care information but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other adverse consequences.

The information disclosed may be subject to redisclosure by the recipient and no longer be protected by the privacy rule.

You are entitled to a copy of this signed authorization form should you desire.

Consent is good for (1) one year from the date signed, unless otherwise specified by you.

(Confidentiality cannot be guaranteed with Faxing)

Signature _____ Date _____ Witness _____

(If patient minor or incapacitated) Personal representative:

Date:

Relationship:

Witness:

Office use only: Date Received and Completed _____

Revised 01/08