

# THOMAS COLLEGE HEALTH CENTER

180 West River Road, Waterville, ME 04901 • Phone: (207) 859-1401 • Fax: (207) 859-1126

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Former or Maiden Name \_\_\_\_\_ Graduation Year \_\_\_\_\_ DOB \_\_\_\_\_

Phone \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

I request that the \_\_\_\_\_ release my Protected Medical Information (medical records) to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Information to be released is as follows:

<input type="checkbox"/> Immunization History	<input type="checkbox"/> Lab Reports
<input type="checkbox"/> Pre-entrance Physical and Health Form	<input type="checkbox"/> Gyn and Pap Reports
<input type="checkbox"/> Complete Progress Notes	<input type="checkbox"/> Complete Medical Records
<input type="checkbox"/> Progress Notes Related to _____	

The purpose of this release is for \_\_\_\_\_

Ex: continued care, school admission, legal, personal

I Do \_\_\_ Do Not \_\_\_ N/A \_\_\_ authorize release of information related to the diagnosis and treatment of Mental Health disorders.

I Do \_\_\_ Do Not \_\_\_ N/A \_\_\_ authorize release of information related to the diagnosis and treatment of HIV infection, AIDS Related Complex-ARC, or AIDS.

I Do \_\_\_ Do Not \_\_\_ N/A \_\_\_ authorize release of information related to the diagnosis and treatment of Alcohol and/or Drug Abuse.

I understand that I can change my mind and request in writing that this release no longer be honored, but that records may have been released before I notified the TCHC of the change. I understand that this release is valid for sixty (60) days only. I release TCHC from any and all liability arising directly or indirectly from disclosure authorized by this consent and any redisclosure of that information.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_