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:

_____ Immunization History

_____ Pre-entrance Physical and Health Form

_____ Complete Progress Notes

_____ Progress Notes Related to _____

_____ Lab Reports

_____ Gyn and Pap Reports

_____ Complete Medical Records

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 _____

Rev. 07/23