AUTHORIZATION TO RELEASE PATIENT-RELATED INFORMATION INCLUDING MEDICAL RECORDS

Patient Name: _____ **ID#:** _____
Maiden or Previous Name(s):_____ Date of Birth: _____ __
Last Year of Attendance at Wheaton College: _____ Phone number: _____

I. Authorization for Release of Information

I, the undersigned, authorize the **WHEATON COLLEGE STUDENT HEALTH SERVICES** and its employees and agents to release and disclose all information about me that they possess (except for the release of information concerning substance abuse, mental health, or HIV/AIDS, unless I have specifically authorized the release of such information in Section II below) to the Recipient(s) identified in Section III below. I understand that unless I state otherwise in this authorization, the information release may include insurance claim or explanation of benefits, intake questionnaires, immunization records, health history records, physical examination records, consultation reports, diagnostic reports, operative reports, laboratory test reports, photographs, videotapes, X-rays, digital or other images, discharge summaries, treatments, prescriptions, and notes of health care professionals. I also authorize the release of information received, obtained, or created after the date on which this Authorization is signed as long as such information is released during the effective period of this Authorization and pursuant to a legitimate request for such information.

II. Specific Authorization for Release of Protected Information (To release this information, you must sign here and at the end of this form.)

I specifically authorize the release of information related to the following checked items:

- ☐ acquired immunodeficiency syndrome (AIDS) or the human immunodeficiency virus (HIV) (including but not limited to test results)
- ☐ substance abuse (drugs(s) or alcohol)
- ☐ mental health, behavior, or psychological/psychiatric care or conditions
- ☐ genetic testing/records

_____ _____ _____
Signature of Patient or Patient's Authorized Representative | Patient's Printed Name | Date

(Include representative's name and a description of the representative's authority: _____)

_____ _____ _____
Witness' Signature | Witness' Printed Name | Date

III. Scope of Disclosure and Duration of Authorization

The information released is to be disclosed to the following persons or entities identified by name or title (the "Recipient(s)"):_____
Fax/Address _____
To release the following information _____. It includes the information identified above regarding all consultations/treatments, except:_____(specify exceptions, if any).

I understand that I have the right to inspect the disclosed information at any time and request a list of entities to whom Wheaton College Student Health Services has released my medical records.

I understand that I may revoke this Authorization at any time (except to the extent that action has already been taken in reliance on it) by delivering to the Wheaton College Student Health Services a signed and written revocation. Unless otherwise revoked, this Authorization will expire on _____ (or on the 365th day from the date of signing if no date is specified).

A photocopy, facsimile, or exact reproduction of this signed Authorization shall have the same force and effect as the original.

Provision of treatment is not conditioned upon my execution of this Authorization or the Specific Authorization for Release of Protected Information contained in Section II of this Authorization.

I have read and fully understand the provisions of this Authorization.

_____ _____ _____
Patient's Signature | Patient's Printed Name | Date

_____ _____ _____
Authorized Representative's Signature | Authorized Representative's Printed Name | Date

(Include description of authorized representative's authority: _____)