Adrian College Health Services

Request for Information Authorization

I, _____ _____ _____
(Full Name) (Student No.) (Birth date)

Authorize the release/exchange of information contained in my record

From: _____
(Person)

_____
(Agency)

_____
(Street)

_____
(City) (State) (Zip)

To: Health Services
Adrian College
Adrian, MI 49221

From: Health Services
Adrian College
Adrian, MI 49221

To: _____
(Person or Agency)

_____
(Street)

_____
(City) (State) (Zip)

Under the conditions listed below:

1. Specific nature of information to be disclosed:

_____ Admission Notes	_____ School Records
_____ Diagnosis	_____ Lab Results
_____ Discharge Summary	_____ Treatment Notes
_____ Treatment Recommendations	_____ Medical History

_____ Other (Specify) _____

2. Purpose for disclosure: _____
3. Unless otherwise indicated, this consent expires: _____

I understand I may revoke this authorization at any time.

_____ _____
Client's Signature Date Witnessed by Date

I wish to revoke this authorization _____
Date