

Manchester College Health Services
Authorization For Release Of Medical Information

Patient's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____

Social Security Number: _____

The undersigned hereby authorizes _____
to release the following portions of the medical records of the above named patient during the
time period of: _____

____ Discharge Summary	____ Lab Reports	____ Emergency Treatment
____ History & Physical	____ X-ray Reports	____ Other, Specify _____
____ Surgery Report	____ Pathology Report	____ Immunization Record

Release This Information To:

Name: _____ Phone: _____
Address: _____ Fax: _____
City: _____ State: _____ Zip code _____

The Medical Record is needed for the following purpose:

____ Attorney	____ Insurance
____ College Enrollment	____ Personal
____ Continued Medical Treatment/F/U	____ Workman's Compensation Claim
____ Disability	____ Other _____
____ Employer	

I understand that I may revoke this release at any time, in writing, but the request shall remain valid until revoked or upon the expiration of sixty (60) days, whichever occurs first, except to the extent that action has been taken thereon.

I also understand that this release may include medical records of treatment for physical and/or emotional illness, including treatment of alcohol or drug abuse. I also understand that HIV, AIDS or AIDS-related and/or communicable disease information may also be released.

Signature _____ Date _____

Witness _____ Relationship _____