BENNINGTON COLLEGE

AUTHORIZATION TO RECEIVE/RELEASE HEALTH CARE INFORMATION

Patient Name ____ DOB ______________________

I request and authorize Bennington College Health Center to: (circle one)

Receive / Release / Receive and Release

the health care information described below to:

____ (Name of Agency/Person)
____Address
____City, State, Zip
____ Phone
____Fax

This authorization covers the following type of information: (check all that apply)

_____Medical
_____Sexually Transmitted infection
_____HIV Test Results
_____Psychological
_____Substance Abuse
_____Other Specific Information: ____________________
____
____

This authorization covers the following means of communication:

_____Verbal and Written _____Verbal Only _____Written Only

My signature below indicates that I hereby release Bennington College from all legal responsibility or liability for the release of the above-mentioned information. I understand that my records are protected under Federal and State confidentiality regulations and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I understand that I have the right to revoke this authorization at any time, except for action already taken, and that such revocation must be in writing. Further, I understand that this authorization, without prior revocation, will automatically expire 90 days from the date of my signature.

Patient Signature ____ Date ________________________

Bennington College Health Services, One College Drive, Bennington, VT 05201
802-440-4426 - Fax: 802-440-4427 - Email: healthservices@bennington.edu