Calvin College Health Services

Authorization for Release of Medical Records & Information

Legal name (please print): _____ Date of birth: (mm/dd/yyyy) _____

Address: _____ City _____ State:_____ Zip: _____

Phone: _____ Date of request: _____

I authorize the release of protected health information:

To / From:	**To / From:**
Calvin College Health Services 160 Hoogenboom Center 3195 Knight Way S.E. Grand Rapids, MI 49546 Phone: 616.526.6187 Fax: 616.526.6548	_____ Name _____ Street _____ City, State, Zip Fax: _____ Ph. _____

Information to be released	**Dates**	**Information to be released**	**Dates**
☐ Health summary & med record *	_____	☐ Immunizations *	
☐ Progress/office visit notes *	_____	☒ Entire record *	
☐ Labs/diagnostic reports *	_____	☒ Other: **Formal Psychological Testing**	

Med sheet, all office notes, for (at least) the most recent two years - plus include all mental health records.

Purpose of disclosure:

☒ Coordination of care with another provider

☐ Continuity of care with another provider

Medical Records must be sent directly from the previous provider. Patient copies are not adequate.

☐ Insurance ☐ School Administration Communication ☐ Legal ☐ Workers compensation

☐ Consultation/2nd opinion ☒ Other Transferring Medical Care while Attending Calvin College

Patient Notification Elements

1. I understand that this authorization will expire 365 days from the date signed.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. It will be effective on the date notified except to the extent that action has already been taken.
3. I understand that information used or disclosed according to this authorization may be subject to redisclosure by the recipient and no longer be protected by the Federal privacy regulations.
4. I understand that if I am being requested to release this information by Calvin College Health Services:
   a) My health care and payment for my heath care will not be affected if I do not sign this form.
   b) I understand I may see and copy the information described in this form if I ask for it, and that I will get a copy of this form after I sign it.

Authorized Signature

X _____ Date: _____

authorized signature

☐ Self ☐ Parent ☐ Legal guardian*

* *A COPY OF LEGAL DOCUMENTATION VERIFYING AUTHORIZATION **MUST** BE ATTACHED*

AUTHORIZED SIGNATURE VERIFIED BY (Health Services staff initials): _____

For Calvin Health Service Use only

Information: _____Mailed _____Faxed _____Placed at front desk to be picked up by Student

Information Sent by: _____ Date: _____

Employee Name/Signature