Parton Center for Health & Wellness
Middlebury College, Middlebury VT 05753
Health Services / Counseling / Sports Medicine

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Student Name: _____ **DOB:** _____/ _____ / _____
Last name *First name* *Middle initial*

Phone number: _____ **Midd Student ID:**_____

I request and authorize the release, use or disclosure of the above named student's protected health information. Please release my health information:

☐ **from** Parton Center for Health & Wellness **to** below: OR ☐ **from** below **to** Parton Center for Health & Wellness:

Name/Organization _____

Street Address/City/State/Zip Code _____

Phone (_____) _____ Fax (_____) _____

I agree to have information exchanged between both parties reciprocally: ☐ ***Yes*** ☐ ***No***

I authorize release, use or disclosure of following information (check all that are applicable):

☐ Immunizations

☐ All clinical information related to specific condition or issue (please specify):
_____

☐ Specific visit/encounter note (please specify):
_____

☐ Lab results (please specify):
_____

☐ Radiology reports (please specify CT, MRI, X-Ray, etc.):
_____

☐ Other (please describe):
_____

Counseling: Please contact Counseling 802-443-5141 to consult with a counselor when checking either of the boxes below.
☐ Counseling summary note(s).

☐ Substance Use Assessment records.

Limit this release to the following dates of service: _____

I have the right to receive a copy of this Authorization, and may revoke it at any time by providing a written notice of revocation; however, such revocation would not affect any action taken by Parton Center for Health & Wellness in reliance on this Authorization before receipt of my written revocation. The information released/disclosed by this Authorization, except information protected by federal regulations about confidentiality of drug and alcohol abuse record, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws. ***Authorization to release this information is valid for 12 months from the date of signature on this release unless otherwise specified above.***

_____/_____ Date_____

Signature of student or personal representative (e.g. legal guardian) / Relationship to patient

Signature of witness: _____Date_____