Center for Health and Wellness
Middlebury College, Middlebury VT 05753

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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

Phone number: **Middlebury 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** Center for Health and Wellness **to** below: AND/OR ☐ **from** below **to** Center for Health and Wellness:

Name/Organization

Street Address/City/State/Zip Code

Phone number: Fax number:

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

I authorize release, use or disclosure of the 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):

I limit this release to the following dates of service:

Center for Health and Wellness
at Middlebury

Center for Health and Wellness
Middlebury College, Middlebury VT 05753

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 Center for Health and 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 or e-signature of student or personal representative (e.g. legal guardian) / Relationship to patient

Signature or e-signature of witness Date

Health Service	Counseling	Sports Medicine	Health and Wellness Education
Office 802.443.5135	Office 802.443.5141	Office 802.443.3636	Office 802.443.2376
fax 802.443.2066	fax 802.443.3407	fax 802.443.2094	