KALAMAZOO COLLEGE

Authorization to Share Medical Information

Student Name: _____ Date of Birth: _____

Student ID #: _____

I authorize the provider listed below to release or disclose health information about me to the Kalamazoo College Student Health Center, the Counseling Center, and/or the Division of Student Development.

Provider's Name: _____

Provider's Address: _____

_____

Provider's Telephone Number: (_____) _____ - _____

Provider's Fax Number: (_____) _____ - _____

Description of Health Information: All pharmacy records; any and all records and documents pertaining to any treatment/consultation rendered or performed, including but not limited to: complete in-patient and outpatient hospital records, surgical records, emergency room records, rehabilitation records, therapy, lab studies, radiographic films and reports, actual office notes, patient files, narrative reports, billings, and medications prescribed and/or filed. This authorization includes alcohol, mental health and substance abuse records, including psychotherapy notes; records protected under the regulations of 42 C.F.R. Part 2, if any; and all records defined by statute and MDPH Rules (Public Act 174, 1989) if any. This authorization applies to any and all records from [date when LOA started] through the date listed below. It applies only to records that are related, in any way, to the reasons for my leave of absence from Kalamazoo College. This authorization also permits oral communications regarding the listed information between agents of Kalamazoo College and the provider identified above. This authorization expires one year after the date below.

Specific Purpose for this Disclosure: This authorization for release of information is provided in connection with my application for reinstatement to Kalamazoo College. I authorize Kalamazoo College to use and disclose this information for any and all purposes associated with my application for reinstatement to the College.

Acknowledgements: I acknowledge and understand the following:

- I am not required to sign this form to receive health care treatment.
- I may see and copy the information described on this form if I ask for it.
- I may revoke this authorization at any time by sending a written revocation to the provider listed above, except to the extent that the provider has already taken action in reliance on this authorization.
- After information has been disclosed based on this authorization, it is possible that the information may be subject to re-disclosure to other individuals at Kalamazoo College.
- My electronic signature on this form, and a copy of the signed form that is duplicated or delivered electronically (e.g. by photocopy, fax, scan, or email) shall be as valid as the signed original.

Signature: _____ Date: _____