Rhodes College
STUDENT HEALTH SERVICES
Student Life

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Pursuant to Federal Guidelines concerning my right to confidentiality, I _____

(**Patient Name**)

authorize _____to release my records to _____

(**Person/Agency**) (**Person/Agency**)

concerning treatment during the period of _____ (**Dates of Treatment**)

and/or records pertaining to _____ (**Specific Diagnosis or Document**)

I understand that I may revoke this consent to release information at any time. However, I also understand that any release made prior to my revocation of this authorization, shall not constitute breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization will expire after one year from date of signature.

_____ _____

Patient Name **Rhodes ID#**

_____ _____

Patient Signature **Date**

_____ _____

Witness Signature **Date**

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