

**Carleton College**  
**Authorization for Release of Information**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may refuse to sign this authorization, and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

Name: \_\_\_\_\_

ID Number: \_\_\_\_\_

I authorize the Group Health Plan and Plan Sponsor to release the following information (Check all that apply).

- \_\_\_\_\_ Address, date of birth, membership status
- \_\_\_\_\_ Benefits
- \_\_\_\_\_ Claims
- \_\_\_\_\_ Psychotherapy Notes
- \_\_\_\_\_ Premium Information
- \_\_\_\_\_ Other (please specify)

Group Health Plan and Plan Sponsor may release information to:

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Number \_\_\_\_\_

Purpose for this Release:

- \_\_\_\_\_ Request of Member or Personal Representative
- \_\_\_\_\_ Other (please specify)

If the information relates to diagnosis or treatment of alcoholism or drug dependency, we must have the name of the treatment facilities or program(s):

\_\_\_\_\_

If the information related to diagnosis or treatment of alcoholism or drug dependency I understand that the person(s) I have named to receive the information must treat it as confidential. The information cannot be disclosed again without another signed authorization from me.

For all information other than diagnosis or treatment of alcoholism or drug dependency, I understand that the person(s) I have named to receive information may not be subject to privacy laws. They may be able to release the information and privacy laws may no longer protect it.

**Right to Revoke**

This authorization is valid for one year after the date it is signed, unless an earlier expiration date is indicated here: \_\_\_\_\_.

\_\_\_\_\_  
Signature of Member

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or other Personal Representative

\_\_\_\_\_  
Date

If this request is by a personal representative on behalf of the Member, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Member: \_\_\_\_\_

**Note:** You have a right to keep a copy of this notice after your sign it.