Information Release Authorization

This form acknowledges consent to: ( )Exchange ( )Release ( )Request information from/between the following:

To/From:	The Wellness Center	To/From:
	Carleton College	
	1 N. College St.	
	Northfield, MN 55057	
phone	(507) 222-4080	
fax	(507) 222-5038	

Patient Name: _____
First Middle Last

Other Names Used: _____ DOB _____

Graduation Year: _____ Phone: _____

I authorize the following information to be disclosed: **Check one**:

( ) ANY and ALL records including drug and alcohol abuse treatment records.
If applicable from date _____ to_____.

( ) SELECTED records.

This consent includes the following: (For Office Use Only)

( )	History and Physical exam	( )	Professional Observations
( )	X-ray Reports	( )	Diagnosis/Treatment Summary
( )	Laboratory Reports	( )	Discharge Information
( )	Immunization Notes	( )	Verbal Consultation
( )	Progress Notes	( )	Psychological Testing
( )	Alcohol/drug abuse records	( )	Psychiatric Treatment
( )	Other _____		

The purpose of this disclosure is:_____

Except to the extent that action has been taken in reliance on this authorization, I may revoke this authorization at any time by sending written notice to The Wellness Center. If this authorization has not previously been revoked, it will expire as of 12 months from date signed or _____ (other date or event).

I understand that the information used or disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law. My health care provider will not condition my treatment on whether I provide authorization for the requested use or disclosure.

_____ _____
Signature of Student or authorized representative Date

_____
Signature of Witness (optional)