Bard Student Health Services

Bard College, PO Box 5000, Annandale-on-Hudson, NY 12504 | Phone: (845) 758-7433 | Fax: (845)758-7437

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Graduation Date: _____

Patient Name: _____
Last First

Date of Birth: _____ SSN XXX-XX- _____
(last 4 digits)

Address: _____
Street City State Zip

Phone: ( ) _____ Email: _____

I hereby authorize Bard Health Service to…

- ☐ Release my health information to:
- ☐ Obtain my health information from:

Name: _____

Address: _____
Street City State Zip

Phone: ( ) _____ Fax: ( ) _____

HEALTH INFORMATION TO BE RELEASED

I specifically authorize the release of the following information:

Initial		*Initial*	
_____	Entire Medical Record	_____	Lab Reports
_____	History/PE Exam	_____	Mental Health
_____	Progress Notes	_____	Xray Reports
_____	Substance Abuse (including alcohol/drug)	_____	Immunization
_____	Other - specify:	_____	

This authorization is made ☐ *at my request,* ☐ *or specify*_____

CONDITIONS OF AUTHORIZATION

1. This authorization will expire on (insert date or event) _____/_____/_____ _____
2. I may revoke this authorization at any time by notifying Bard Health Service and it will be effective on the date notified except to the extent that Bard Health Service has acted upon such Authorization
3. Information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer protected by Federal privacy regulations.
4. By authorizing this release of information, my healthcare and payment for my health care will not be affected if I do no sign this Authorization form.

Signature _____ Date _____

Witness _____ Date _____