AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH INFORMATION

Regarding Patient (see reverse side for additional information)

Legal Name: -Last, First, MI		Date of Birth:
Street Address:		Bowdoin ID#
City:	State:	Zip Code:

1. Information Released To From

Name: Bowdoin Health and Counseling Services and Treating Provider(s) (if desired)		
Street Address: 3600 College Station		
City: Brunswick	State: ME	Zip Code: 04011
Phone #: 207.725.3770	Fax#: 207.725.3515	
Email: healthservices@bowdoin.edu ;		

2. Information Released To From

Within Bowdoin College:

Dean's office	Wellness Coach
Registrar/Recording Committee	Risk Management
Professor	Director of Student Accessibility
Dietician	Eating Disorder Team
Athletics (Coach, Trainer)	CARE team

Outside of Bowdoin College:

Name (Individual or Class of Individuals at a particular entity, Lawyer, Parent, etc.):		
Street Address:		
City:	State:	Zip:
Phone #:	Fax#:	Email:

3. By initialing here I permit the parties listed in #1 and #2 to share my confidential health information with each other (bidirectionally) _____

Laboratory Results	Office Visits	Mononucleosis Infection
Medication List		

Federal and State laws require special permission to release the following certain information. Check below to authorize release of:

Mental Health	Substance Use	HIV/AIDS

5. Purpose of disclosure:

Coordination of care	Transfer of Care	Academics	Other