Earlham College Health Services

Consent for Release of Confidential Information

I, _____, ____-____-____
(Full name) (Social Security Number)

authorize _____
(name of practitioner making the disclosure)

_____
(address and phone of person making the disclosure, if needed)

_____

to disclose to _____
(name of person/organization to whom disclosure is made)

_____
(address and phone of person/organization, if needed)

_____

the following information: _____

_____

_____

I understand that my records are confidential and cannot be disclosed without my written consent unless required by law. I also understand that I have no obligation to disclose the requested information and may revoke this consent at any time by informing the above individuals in writing of my desire to do so. I further understand that this authorization is valid for a period of 180 days unless otherwise specified: _____.

_____ _____
Signature of client Date

_____ _____
Signature of Witness