BARTON COLLEGE

Release of Confidential Information

(please print)

I, _____ authorize Barton College,

Lee Student Health Center, to release medical records to _____.

Type of Information to be released:

- ☐ Pap Results
- ☐ Lab Results
- ☐ Immunization Records
- ☐ Physical Exam
- ☐ Medications Prescribed
- ☐ Diagnosis
- ☐ Other _____

Please send my records to:

Agency _____

Fax (_____) _____ - _____

Address _____

City _____ State _____ Zip _____

I understand that I am giving Barton College permission to disclose confidential information to the agency that I have named above. I may revoke this permission at any time with written notice. This release expires 12 months from the date signed unless otherwise specified.

Name (please print) _____

Social Security # _____

Signature _____

Date of Birth

_____

Date of Last Attendance

_____

Date Information Requested

_____

Lee Student Health Center
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