th Fax: 641-269-49 88 **Your Right to Medical Information Confidentiality: :**Yregarding yvsits to: Except in limFed :circumstances, i

Patient/Student's Name:____

Date of Birth:_____________ P-Card Number: __________________

I authorize Grinnell College's Student Health and Wellness to release/exchange health and/or counseling information about me to:

Name of Person/Entity: ____

Address: ____

City, State, Zip:____

Phone:___________________________________ Fax:_____________________

Authorization to Release/Exchange Information continued…

Type of Information to be Released/Exchanged:

Counseling Records

All

Specifically related to: ___

Medical Records

All

Specifically related to:

Recommendations

Other type of information to be released

Any types of Records to be excluded:

I understand that the information is to be used for:

Academic considerations

Coordination of services/continuity of care

Assessment of functioning requested for off-campus programs (Peace Corps, or other applications).

Other use of released information________________________________

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