Authorization to Release Health Information

For patients

The Cox Health and Counseling Center at Kenyon College keeps all medical information about patients private. Patients may authorize the release of information to specific individuals by completing this form.

PATIENT AUTHORIZATION

I, the undersigned, authorize the Cox Health and Counseling Center to release my health information from the categories checked below to the person(s) I designate on this form for the purpose so stated. *Please check all boxes that apply.*

Patient name (printed) _____ Patient's date of birth _____

Address _____ Telephone number _____

The following types of information may be released (check all appropriate boxes):

☐ Entire report ☐ Laboratory report ☐ Office notes ☐ Radiological report
☐ History/physical exam ☐ Medication/allergy ☐ Radiological images ☐ Other _____

Date of service: _____

☐ I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral mental health and treatment for alcohol or drug abuse.

☐ I understand health information in my record may contain documents from the other healthcare providers used in whole or in part by the hospital and affiliated clinical services.

☐ I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Cox Health and Counseling Center.

☐ I understand authorizing the use or disclosure of the information identified above is voluntary. Signing this form has no impact on healthcare treatment.

This authorization will expire (choose one):

☐ When this request is completed
☐ In _____ days (not to exceed 365)

RELEASE OF INFORMATION

The information above may be released or disclosed to the following individuals:

Name: _____ Telephone: _____

Address: _____ Fax: _____

Name: _____ Telephone: _____

Address: _____ Fax: _____

SIGNATURE

Patient signature _____ Date _____

Kenyon College
Cox Health and Counseling Center

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