ADRIAN COLLEGE
STUDENT HEALTH CENTER

Phone: (517) 265-5161, ext. 4214 **Fax:** (517) 264-3112

AUTHROIZATION FOR RELEASE OF INFORMATION

Name: ____ Date of Birth: _________________________

Student ID #: _____________________ Student Phone Number: __________________________________

AND/OR

I authorize Adrian College Counseling and Medical services to disclose my information to:	I authorize Adrian College Counseling or Medical services to obtain information from:
_______________________________________	_______________________________________
Name of Provider or Facility	Name of Provider or Facility
_______________________________________	_______________________________________
Address	Address
_______________________________________	_______________________________________
City, State, Zip Code	City, State, Zip Code
_______________________________________	_______________________________________
Phone (please include area code)	Phone (please include area code)

Effective Date: This authorization for release of information covers the period of healthcare from:

☐ Current school year only. ☐ All past, present, and future periods. ☐ Other: ___________________________

Specific information Authorized: (select on or more as appropriate)

☐ Assessments	☐ School records	☐ Other (please describe):
☐ Progress Notes	☐ Laboratory results	
☐ Laboratory	☐ Treatment Notes	________________________________
☐ Diagnosis	☐ Treatment Plans	
☐ Discharge Summary	☐ Medical History	________________________________

I understand that my treatment of eligibility for services will not be condition on whether I sign this authorization. Additionally, I understand that I may limit the exchange of information to medical or counseling only.

Student Signature: ____ Date: _______________________

Revised 10/2020