BRYN MAWR HEALTH CENTER **610.526.7360**

Authorization For Disclosure Of Healthcare Information

Name _____Date of Birth _____

Address _____

City, State, Zip_____ Phone Number_____

Name while at Bryn Mawr (if different) _____

Graduation Year _____ BMC ID Number (if available) _____

Was your original graduation year different? YES/NO If yes, what was your original year? _____

I authorized BMC Health Center,101 N. Merion Ave, Bryn Mawr, PA 19010 to **receive / disclose (circle one)** information contained in my medical records **from/to (circle one):**

Name of Person or Institution _____

Address_____

City/State/Zip Code _____ Country _____

Phone Number _____ Fax Number _____

Release the following information:

□ X-ray reports
□ Provider notes
□ Lab test results
□ Immunizations
□ GYN
□ Admission history and physical
☐ Other _____

Covering the period(s) of care (list applicable dates of treatment): _____

Authorization

I hereby authorize the Bryn Mawr College Health Center to release the information described above. I understand that information related to HIV and emotional health or drug and alcohol concerns related to my medical care may be released as part of my health information. This authorization will expire in 90 days. I may revoke this authorization in writing. I understand that such revocation will not apply to anything which has already been sent.

Purpose of Releasing Information:

☐Continuation of care
☐Legal Purposes
☐ School / Job Purposes
☐ Other: _____
☐ Insurance Purposes

Signature _____ Date:_____

Bryn Mawr College Health Center
101 N. Merion Ave
Bryn Mawr, PA 19010
Phone (610) 526-7360 Fax (610) 526-7365