Grinnell College
Student Health and Wellness

Authorization to Release/Exchange Information

Grinnell College
Student Health and Wellness (SHAW)
1119 6th Avenue
Grinnell, Iowa 50112
Phone: 641-269-3230
Fax: 641-269-4988

Your Right to Medical Information Confidentiality: You have the right to confidentiality regarding your visits to the Student Health and Wellness center. Except in limited circumstances, in order to release any information including the nature of your visit, Student Health and Wellness will need your signed authorization and specific directions about what information is to be released.

Patient/Student's Name:_____
(Printed)

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_____

Special Authorization to Release/Exchange Information Regarding:

- ☐ Alcohol/drug abuse
- ☐ HIV-related information

I understand that I am giving my permission to Grinnell College Student Health and Wellness to disclose confidential counseling and/or health records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to Student Health and Wellness. I acknowledge receipt of a copy of this Authorization

This release expires in one year unless another date is specified. _____

Release/Exchange Information Authorization obtained by: _____

Patient/Student Signature: _____

Date:_____