Health Services
1700 S. Main St.
Goshen, IN 46526-4724
Phone: 574-535-7474 Fax: 574-535-7195

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Date: _____

Patient Name **(print)**: _____

Address: _____
mailing address city state zip

Date of Birth: _____ GC Student ID#: _____

Phone: _____

I authorize Goshen College Health Services to obtain medical information of the above named individual as described below:

_____ Chart notes _____ Lab results _____ ER Records

_____ Medication(s) _____ Test(s)/Procedure(s) _____ Mental Health Records

_____ Immunization Record _____ Other _____

Information to be obtained from: _____
name of agency

_____
address city state zip

_____ _____
phone number fax number

I understand the information may be communicated via fax, photocopy, verbal communication, telephone, voice mail, email, and/or direct mail.

The information being disclosed/obtained is for the following purpose: _____

_____

I understand that I may revoke this release at any time in writing except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date below. I also understand that this release may include medical records of treatment for physical and /or emotional illness, including the treatment of alcohol or drug abuse. HIV, AIDS or AIDS-related and/or communicable disease information may also be released.

Signature of patient: _____ Date: _____