AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I,_____, _____, hereby authorize
Name Date of Birth

Kenyon College Health and Counseling Center
Gambier, Ohio 43022
740-427-5525
Fax - 740-427-5527

- ☐ Release Information To:
- ☐ Receive Information From:
- ☐ Mutually Exchange Information With:

Name: _____

Address: _____

_____

Telephone: _____

Fax: _____

Information to Be Released: _____

_____

_____

_____ _____
Patient or Next of Kin Witness

_____
Relationship (If Next of Kin)

_____
Date

This expires: ○ Upon graduation from Kenyon
○ Date: _____

*Note: There may be references to psychological consultations in your medical records. Please specifically note whether they are to be included or excluded in your request. This may be done under a separate letter or by phone to avoid breach of confidentiality.