AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

By **initialing** the spaces below, I, ________________________________ DOB _____________ hereby authorize,

LE MOYNE COLLEGE, Wellness Center for Health and Counseling to:

_______ release information to _______ obtain information from: _______ exchange information ***verbally*** with:

Name: ____ Phone: _________________________________

Street: ____ Fax: __________________________________

City: ____________________ State: ______ Zip: ______________

The information will be used on my behalf for the following purpose(s): ____

____

By **initialing** the spaces below, I specifically authorize the release of the following medical records, *if such records exist:*

____ **Any or all Medical Records** needed for continuity of care

____ Clinic office chart notes
____ Physical therapy records
____ Emergency and Urgent care records
____ Laboratory reports
____ Pathology reports
____ Medication records
____ Immunization records

____ **Mental Health** information (*must be initialed to be included in other documents*)