SAINT MICHAEL'S COLLEGE FOUNDED 1904

Release of Information

Bergeron Wellness Center

I, _____, (please print) DOB: _____/_____/_____

hereby authorize Bergeron Wellness Center to: _____release to, _____receive from:

Name (if other than yourself) _____
Address _____
_____
_____
Phone _____ Fax _____

The purpose(s) of disclosure:
_____ to assist in coordination of care and treatment planning
_____ to assist in transfer of care to alternate provider
_____ for my personal records
_____ other:_____

Form of disclosure: _____Written, _____Verbal, _____Electronic

I authorize release of the following information (check all that apply):
_____ Immunizations
_____ Entire record
_____ Counseling and/or Psychiatry notes limited to: _____
_____ Most recent general history and physical examination
_____ Other _____

I understand that:
My records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2), and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Recipients of this information may re-disclose it only in connection with their official duties. I may revoke this consent at any time except in the obvious circumstance that action has already taken place. This consent expires one year from the date of signature. A fee may be assessed for a copy of protected health information.

_____ Date _____/_____/_____
Signature of patient or legal guardian

_____ Date _____/_____/_____
Signature of Witness
01/2016