# Release of Information (ROI) Authorization Form

This form acknowledges consent to: ( )Exchange ( )Release ( )Request information from/between the following:

| To/From: Student Health and Counseling<br>Carleton College<br>1 N. College St.<br>Northfield, MN 55057<br>phone (507) 222-4080<br>fax (507) 222-5038 | To/From: |
|---|---|

Patient Name:______________________________________________________
First Middle Last

Other Names Used: _____________________________________ DOB ___________

Graduation Year: ___________ Phone: ____________________________________
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I authorize the following information to be disclosed: **Check one**:

( ) ANY and ALL records including drug and alcohol abuse treatment records.

If applicable from date _______________to _______________.

( ) SELECTED records

This consent includes the following: (For Office Use Only)

( ) History and Physical exam
( ) X-ray Reports
( ) Laboratory Reports
( ) Immunization Notes
( ) Progress Notes
( ) Alcohol/drug abuse records

( ) Professional Observations
( ) Diagnosis/Treatment Summary
( ) Discharge Information
( ) Verbal Consultation
( ) Psychological Testing
( ) Psychiatric Treatment

( ) Other Communication: _____________________________

The purpose of this disclosure is: ____________________________________________________________
Except to the extent that action has been taken in reliance on this authorization, I may revoke this authorization at any time by sending written notice to Student Health and Counseling. If this authorization has not previously been revoked, it will expire as of 12 months from date signed (Initial: ________) or ______________________________ (other date or event).
I understand that the information used or disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law. My health care provider will not condition my treatment on whether I provide authorization for the requested use or disclosure.

_______________________________________________________________________________

Signature of Student or authorized representative Date

_______________________________________________________________________________

Signature of Witness (optional)