Hamilton
OPPORTUNITY PROGRAMS

Fax: 315-859-4912
Phone: 315-859-4398

## Authorization to Release Health Information

I, _____ authorize Hamilton College Student Health
( student name)

Center to release my medical information to: OR receive information from:

Name: **Phyllis Breland (Director) and Brenda Davis (Assistant Director)**

Address: **Opportunity Programs, 198 College Hill Rd., Clinton, NY 13323**

Phone/Fax: **(315) 859 – 4398 / (315) 859-4912**

What Information to be released: Health Information
Other: _____

I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing. This authorization will expire at the end of the summer session on August 2, 2019.

Signature of Patient _____
Date: _____

**If student is under the age of 18, an additional signature is required:**

Signature by Legal Representative, Relationship to Patient: _____
Date: _____

Signature of Witness: If applicable _____