

Patient/Student's Name:

P-Card Number:

I authorize Grinnell College's Student Health and Wellness to release/exchange health and/or counseling information about me to:

Fax:_____

Address:

Phone:

City, State, Zip:_____

Authorization to Release/Exchange Information continued...

Type of Information to be Released/Exchanged:	
	Counseling Records
	All
	Specifically related to:
	Medical Records All
	Specifically related to:
	Recommendations
	Other type of information to be released
Any types o	f Records to be excluded:
l understan	d that the information is to be used for: Academic considerations
	Coordination of services/continuity of care
	Assessment of functioning requested for off-campus programs (Peace Corps,
	or other applications).
	Other use of released information