SMITH COLLEGE

Schacht Center for Health and Wellness
Pelham Medical Services
Northampton, Massachusetts 01063
T (413) 585-2250 F (413) 585-4639

Authorization to Obtain Records from Outside Provider/Agency

I, _____ DOB: _____,

give permission to: _____

Address: _____

Fax: _____

to release to: **Smith College Medical Services**
21 Belmont Avenue
Northampton, MA 01063
Fax: (413) 585-4639

Whatever information the doctor deems pertinent about my medical history, treatment and care.

_____

(please specify which medical records you require)

I hereby release Smith College from all legal responsibility or liability that may arise from the act I have authorized above.

I voluntarily consent to the release of this information. I understand that I may revoke this consent at any time unless action on it has begun, through written, dated communication.

This authorization expires in one year.

_____ _____

Patient Signature/Class Witness

_____ _____

Print Patient Name Date