

Barton College
Lee Student Health Center
PO Box 5000
Wilson, NC 27893
Phone (252) 399-6397
Fax (252) 399-6548

Release of Confidential Information

I, _____, authorize Barton College to release the following medical records to _____.

Type of Information to be released:

_____ Diagnosis
_____ Immunization Records
_____ Lab Results
_____ Medications Prescribed
_____ Pap Results
_____ Physical Exam
_____ Other: _____

Please send my records to:

Agency: _____
Fax: _____
Address: _____

I understand that I am giving Barton College permission to disclose confidential information to the agency that I have named above. I may revoke this permission at any time by written notice.

This release expires 12 months from the date signed unless otherwise specified.

Name: _____
Signature: _____
Social Security #: _____
Date of Birth: _____
Date Requested: _____
Date of Graduation/Transfer: _____
Witness: _____