

## **Authorization For Disclosure Of Healthcare Information**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone Number \_\_\_\_\_

Name while at Bryn Mawr (if different) \_\_\_\_\_

Graduation Year \_\_\_\_\_ BMC ID Number (if available) \_\_\_\_\_

Was your original graduation year different? YES/NO If yes, what was your original year? \_\_\_\_\_

I authorized BMC Health Center, 101 N. Merion Ave, Bryn Mawr, PA 19010 to **receive / disclose (circle one)** information contained in my medical records **from/to (circle one)**:

Name of Person or Institution \_\_\_\_\_

Address \_\_\_\_\_