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____