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_____