Springfield College Health Center
263 Alden Street
Springfield, Massachusetts 01109
Phone: (413) 748-3175 Fax: (413) 748-3444
Healthcenter@springfieldcollege.edu

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name:_____ Former name (if applicable): _____

Date of birth:_____ Student ID#:_____ Phone:_____ Year of Graduation_____

Permission is hereby given for Springfield College Health Center to release the following information from the medical record.

INFORMATION REQUESTED:

☐ Immunizations/PPD ☐ Physical Exam ☐ Office Visit* ☐ Laboratory* and Imaging Reports

Date(s) of Services: _____

*For information of a sensitive nature including STD results and Mental Health, please provide additional authorization below:

☐ I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed.

☐ I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed.

METHOD OF RELEASE:

☐ Pick up in office ☐ Mail ☐ **Fax ☐ **E-mail

**By requesting release by fax or e-mail you accept the risk and consequence of potentially unsecure methods

AUTHORIZATION TO RELEASE TO:

Name: _____

Address: _____

Telephone: _____ Fax: _____

Email: _____

THIS AUTHORIZATION IS VALID FOR 90 DAYS FROM THE DATE OF SIGNATURE

I understand that I may revoke this consent in writing at any time, except to the extent that action has already been taken in response to this authorization. I also release Springfield College Health Services from any liability or legal responsibility in connection with the release of the above information. I understand a fee may be charged for copying medical information.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

For Office Use: Date Completed: _____ # of Pages Copied: _____ Staff Initials: _____