

Springfield College Health Center
263 Alden Street
Springfield, Massachusetts 01109
(413) 748-3175
(413) 748- 3444 (fax)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name: _____ Date of birth: _____

SSN: _____ ID#: _____ Phone: _____

Permission is hereby given for Springfield College Health Services to release / request the following information from the medical record: { } **RELEASE TO** { } **REQUEST FROM**

Name: _____

Address: _____

Telephone: _____ Fax: _____

- Complete health record Immunizations Clinical notes Physical exam Gyn exam
 Laboratory report(s) Other: _____

PURPOSE FOR RELEASE OF INFORMATION: _____

I understand that the information to be released may include information protected by federal and state laws. By initialing below, I authorize the disclosure of the following information:

Sexual assault: _____	HIV/AIDS: _____
Mental Health: _____	HIV testing results: _____
Drug/Alcohol: _____	Sexually Transmitted Disease: _____
Contraception: _____	Other: _____
Pregnancy: _____	

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

METHOD OF RELEASE:

- Mail directly to Springfield College Health Services Permission to fax
 Patient picks up information in person Information sent by mail
 Verbal / Telephone Other: _____

Patient Signature

Date

Witness Signature

Date

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