ELMS COLLEGE
HEALTH CENTER
291 SPRINGFIELD STREET
CHICOPEE, MA 01013
PHONE: 413-265-2288 FAX: 413-592-9939

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete form thoroughly. Copies of your medical record cannot be released until this form is completed, signed by the student or legal guardian (if under age 18).

STEP 1: Information about you: **PLEASE PRINT!**

NAME: ____ OTHER NAMES (eg, maiden): ________________________
Last First MI

STUDENT ID#: ________________________ DATE OF BIRTH: _____________ PHONE NUMBER: ______________________

COLLEGE STATUS: _____current student ______graduate (year_________) ______inactive (years attended _____________)

STEP 2: Method of release:

_______ PERSONAL PICKUP WITH A PHOTO ID ________ PHOTOCOPIES SENT BY MAIL/EMAIL

________ TELEPHONE / VERBAL ________ PERMISSION TO FAX

STEP 3: To whom do you wish to release your records to or obtain your records from? **PLEASE PRINT!**

TO/FROM (NAME OF PERSON/FACILITY, ADDRESS, PHONE OR FAX NUMBER AS APPLICABLE):

____

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____

RELEASE THE FOLLOWING INFORMATION:

_______ ENTIRE HEALTH RECORD _________ IMMUNIZATION INFORMATION ONLY ________ OTHER: _______________________

_______ SPECIFIC DATES OF TREATMENT: FROM ________________ TO ___________________

FOR THE PURPOSE OF: ________ CONTINUITY OF CARE ________ WORK/SCHOOL _______ OTHER: ____________________________

STEP 4: Authorization and signature:

I hereby authorize _______________________________________ to release the records as described above. This authorization is valid for 60 days and may be revoked at any time in writing prior to the expiration date. I do not give permission for any other use or re-disclosure of this information.

___________________________________ _____________________________________ ________________
Patient Signature Guardian Signature (if under 18) Date

STEP 5: Release of Sensitive Information:

I hereby authorize ____________________________________ to release all information in such records, including **mental illness, alcoholism, drug abuse, sexually transmitted disease, or HIV test, if any.**

____________________________________ _______________________________________ _________________
Patient Signature Guardian Signature (if under 18) Date