ELMS COLLEGE

291 Springfield Street
Chicopee, MA 01013-2839
413-594-2761
www.elms.edu

HEALTH CENTER
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PHONE: 413-265-2288 FAX: 413-592-9939

Please complete form thoroughly. Medical documentation cannot be released until this form is completed and signed by the student or legal guardian (if under age 18)

PLEASE PRINT!

STEP 1: Information about you:

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?

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

_____

_____

RELEASE THE FOLLOWING INFORMATION:

☐ PHYSICAL EXAM ☐ IMMUNIZATION ☐ TB TESTING ☐ 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