

**Emerson College, Center for Health & Wellness
Authorization for Release of Medical Information**

Student Name: _____ ID#: _____ Date of Birth: _____
(Please Print)

Address: _____ City: _____

State: _____ Zip: _____ Phone: (H) _____ (W) _____

Year of Graduation/ Separation: _____

I hereby authorize (name of person/facility) _____ to:
 _____ **Release** the information indicated below to **Emerson College's, Center for Health and Wellness**
 _____ Speak or correspond with Emerson College, Center for Health & Wellness regarding my treatment
 at/by _____

I hereby authorize the Emerson College's, Center for Health and Wellness (EC/CHW) to:
 _____ Release my medical information specified below to the following person/facility:
 _____ Speak or correspond with the following clinician or person regarding my treatment at EC/CHW:

Name (Person or Facility): _____ Phone #: _____
(Please Print)

Address: _____ Fax # _____

_____ Send via U.S. Mail
 _____ Patient to pick up this information at the Center for Health & Wellness, 216 Tremont Street, Boston, MA
 _____ Fax information to _____ at Fax # _____

I understand that EC/CHW may charge a fee for copying and mailing my medical record.

Special Authorization for Release of Statutorily Protected Information from the Medical Record

The following categories of information in your medical record **WILL NOT** be released unless you indicate your specific authorization with your signature below.

I hereby authorize EC/CHW to release all information in my medical record related to:	Signature
Behavioral Health Information	
Diagnosis and Treatment of Alcohol or Drug Abuse	Additional Release required
AIDS/ARC and/or HIV testing and results	
Abortion	
Sexual Assault	
Domestic Violence	
Sexually Transmitted Diseases (STDs)	
Mammography Reports	

Specify information to be released—Please initial and date:

_____ Office Visit Notes from (Dates): _____ Initial here for **ALL Office visit notes** _____

_____ Annual GYN Exam and PAP Smear Results (Specify date/s) _____

_____ Immunization Dates/Records

_____ Verification of Office Visit on (Date): _____, _____
(Month) (Day) (Year)

_____ Notification to Dean of Students/Faculty of Absence Due to: _____

_____ Laboratory/X-Ray Reports (Specify test date) _____ **EXCEPT** the following: _____

Purpose of Disclosure (check all that apply):

_____ Medical Care _____ Legal _____ Insurance _____ Personal _____ Leaving Emerson College _____ Other: _____

I understand that once Emerson College, CHW discloses my health information to the recipient, Emerson College cannot guarantee that the recipient will not disclose my health information to a third party. Such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at EC/CHW.

I understand that this Authorization will remain in effect until the term of this Authorization expires or until I provide a written notice of revocation to EC/CHW at the address provided below. The revocation will be effective immediately upon EC/CHW's receipt of my written notice, EXCEPT that the revocation will not have any effect on any action take by EC/CHW in reliance on this Authorization before it received my written notice of revocation.

This Authorization will be valid for 90 days from the signature date, or until (Date): _____.

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Emerson College, Center for Health and Wellness, to disclose my health information in the manner described above.

Student Signature

Date

Signature of Personal Representative

Relationship to patient (parent/guardian)

Please mail or fax this Authorization to the following address:

**Emerson College, Center for Health and Wellness
120 Boylston Street
Boston, MA 02116**

Fax: 617-824-7897