Curry College Health Services
1071 Blue Hill Avenue
Milton, MA 02186
617-333-2182
Fax 617-333-2029

# MEDICAL RECORD RELEASE / REQUEST AUTHORIZATION

NAME……Date of Birth……Phone.....

ADDRESS: ……..……..

Street, City, State, Zip

I hereby authorize Curry College Health Service to

- ☐ Release information concerning the person named above to the following:
- ☐ Disclose information concerning the person named above to the following:
- ☐ Request information concerning the person named above from the following:

NAME……..

ADDRESS: ……..

Street, City, State, Zip

PHONE……FAX……

- ☐ Release my immunization record
- ☐ Release only the following specific information in such records (state illness and /or treatment and dates)
  ……..
  ……..
- ☐ Release all information in my medical record (including information regarding mental health, dg or alcohol abuse, sexually transmitted diseases, or HIV related information including testing)
- ☐ Release all information in my medical record except for
  - o Mental health
  - o Drug or alcohol abuse
  - o Sexually transmitted diseases
  - o HIV related information including testing

I understand that my records are maintained in accordance with the Family Education Rights and Privacy Act and the General Laws of Massachusetts and cannot be disclosed without my written consent except as otherwise provided by law.

I have read this notice and consent prior to signing and I understand its contents.

Signed……. Date……..

Signature of Patient (*Legal Guardian if under 18)

(*Relationship to Patient)……

Witness……. Date……

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**For Health Services Use Only:**

Faxed Mailed Emailed Picked Up Date…….. Initials……