# CURRY COLLEGE
# HEALTH SERVICES

1071 Blue Hill Ave
Milton, MA 02186
617-333-2182
Fax 617-333-2029

## MEDICAL RECORD RELEASE AUTHORIZATION

***Section 1***

Name: _____ SS #: _____

Address: _____
Street, City, State, Zip

Date of Birth: _____ Phone #: _____

***Section 2***

**X** - I hereby authorize Curry College Health Services to send the record of my care to:

Name: _____

Address: _____
Street, City, State, Zip

Phone: _____ Fax: _____

***Section 3***

For the purpose of: ❑ Consultation ❑ Treatment ❑ Required information ❑ Other _____

***Section 4 – Please check options below:***

___Release my immunization record

__ Release HIV antibody and antigen testing from my medical record

__ Release all information in my medical record (including information regarding mental health, drug or alcohol abuse, sexually transmitted diseases, or HIV related information, including testing).

__Release all information in my medical record, except for:

- ❑ mental health
- ❑ drug or alcohol abuse
- ❑ sexually transmitted diseases
- ❑ HIV related information, including testing

__ Release only the following specific information in such records (state illness and / or treatment and specify dates):

_____

_____

***Section 5***

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.

Any information released or received as a result of this consent shall not be further relayed in any way to any other person, organization, entity or other without an additional written consent from me. I may withdraw this consent by giving written notification to the above party, at any time prior to the disclosure or release of the information. In the absence of my prior withdrawal, this consent will expire 180 days after it is signed.

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

Signed _____ Date: _____
Signature of Patient (*or Legal Guardian if under 18)
(*Relationship to Patient) _____

Witness: _____ Date: _____

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*For Health Services Office use only:*

❑ Faxed ❑ Mailed ❑ Picked Up Date: _____ Initials: _____