Division of Student Life and Academic Development • Student Health Service •
29 Everett Street, Cambridge, MA 02138
Phone 617.349.8222 Fax 617.349.8225

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____ DOB: _____

Home Address: _____

☐ Resident ☐ Commuter Graduation Year: _____

I authorize Lesly University Student Health Service to: ☐ **Receive information from** ☐ **Release information to**

Name: _____

Address: _____

Phone: _____ **Fax:** _____

Information to be released:

☐ Complete Medical History ☐ Physical Exam ☐ Immunizations

☐ Other: _____

Purpose of disclosure: _____

The following information will NOT be included unless initialed:

____ Family Planning ____ HIV/AIDs Status ____ Genetic Testing

____ Sexually Transmitted Diseases ____ Drug & Alcohol Treatment ____ Mental Health Records

This authorization will remain in effect until:

☐ The end of the current academic year (May 30, 20____)

☐ Other: _____

My signature below acknowledges that:

- I have had an opportunity to ask questions about the use and disclosure of my health information, and I knowingly and voluntarily authorize disclosure of the information above to the persons or agencies listed.
- I understand that I may revoke this authorization at any time by submitting a written request to the Lesley University Student Health Service (SHS), but that it may not be possible to cancel my permission to share if my information has already been shared at the time my authorization is revoked.
- Declining to sign or submit this authorization, or cancellation of this authorization, will not affect my care at SHS.

Signature of patient or legal representative: _____ **Date:** _____

If patient is not signing, please indicate representative's authority to sign:

_____