TUFTS UNIVERSITY HEALTH AND WELLNESS SERVICE

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Name (Print): ____

ID#: ____________________________________ DOB: ____

Phone: _________________________________ E-Mail: ____

I authorize Tufts University Health and Wellness Service to:

- ☐ Release copies of my protected health information as specified below to the following person or facility: **OR**
- ☐ Communicate verbally with the following person or facility as specified below:
  Please Note: It is the Health and Wellness Service's policy not to accept unlimited advance permission to discuss all medical matters. We ask for consent on a situation by situation basis.

Name of Person or Facility to receive protected health information:

□ Communicate with: __________________________________ □ Picked up by: _____________________________________

□ Fax to: ______________________ □ Mail to: ____

I specifically authorize the use and/or disclosure of the following information (Initial appropriate selection as applicable):

____ All of the information in my general medical record, including any information relating to sexually transmitted diseases, and HIV/AIDS, including test results and the fact that tests were taken.

____ Psychiatry or mental health counseling and behavioral health records

____ Specific information to be communicated verbally (Expiration date: ________________)

____

____ Other: ____

I understand that:

- I may refuse to sign this authorization. I understand that my refusal will not affect my ability to obtain treatment at Tufts Health and Wellness Service.
- I may revoke this authorization at any time by submitting a written notice of revocation to Tufts Health and Wellness Services at the address listed on page 2. The revocation will be effective upon Tufts Health and Wellness Service's receipt of my written notice, except that it will not have any effect on any action already taken by Tufts Health and Wellness Service in reliance on this authorization.
- Once Tufts University Health and Wellness Service has disclosed my health information to the recipient, Tufts Health and Wellness Service cannot guarantee that the recipient will not redisclose my health information to a third party.
- This authorization will automatically expire in 90 days unless otherwise specified here: __________________ (Date of expiration)

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do expressly and voluntarily authorize disclosure of the above information about, or medical records of, my conditions to those persons or organizations listed above. I also confirm that I am at least 18 years of age.

Signature: ____ Date: _____________________________

Parent or Guardian (name, signature and relationship): ____

For Office Use Only*:*

☐ Paper copy in a designated record set sent as requested by: ____, on:____________________

☐ Electronic copy sent as requested by: ____, on:____________________

Detail of information: ____

M Higham 11/16

TUFTS UNIVERSITY HEALTH AND WELLNESS SERVICE
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO OUR OFFICE

Name (Print): ____

ID#: ___________________________________ DOB: ____

Phone: _________________________________ E-Mail: ____

Name of Facility or Doctor: ____ Fax #: ____________________

I specifically authorize the release of my protected health information (Initial appropriate selection as applicable):

____ Specific Information: ____

____

Please send copies of my protected health information as specified:

Attention to: ____

Tufts University Health Service
124 Professors Row
Medford MA 02155

Fax# 617-627-3592

Signature: ____ Date: _____________________________

For Office Use Only*:*

☐ Called provider on:____________________________, spoke to:____

Detail of information: ____

M Higham 6/16