



Health Service

Wellesley College

106 Central Street
Wellesley, Massachusetts 02481
(781) 283-2810 Fax: (781) 283-3693

AUTHORIZATION TO OBTAIN / RELEASE MEDICAL INFORMATION

PATIENT NAME:	_____		
	(LAST)	(FIRST)	
HOME ADDRESS / DORM:	_____		
TELEPHONE: (HOME) _____ (CELL) _____	DATE OF BIRTH:	YEAR OF GRADUATION:	

I _____ do hereby authorize _____ to obtain / release my protected health information including copies of my medical record of care from / to the following:

PERSON / FACILITY & ADDRESS: (Phone / Fax)	_____
INFORMATION REQUESTED	_____ COMPLETE COPY OF MEDICAL RECORD _____ IMMUNIZATION RECORDS ONLY _____ OTHER:
Please check one of the following:	
_____ TO PICK -UP _____ TO MAIL _____ TO FAX	

I understand that the information contained in my medical record is considered to be of confidential nature and may contain **MEDICAL, PSYCHIATRIC, DRUG, and ALCOHOL ABUSE INFORMATION**. Wellesley College will only release / use this information in accordance with my authorization and State and Federal regulations.

I have carefully read this form and I hereby release Wellesley College from all legal liability that may arise from the release of / medical use of the requested information. This authorization shall remain in effect for 6 months. I understand that this authorization may be revoked at any time by giving written notice to Wellesley College. Federal regulations prohibit any further redisclosure of this information other than as specified above.

(Signature of Patient)

(Date)

Mention of / Treatment for **HIV / AIDS** test results and/or diagnosis.

THERE IS A \$15 FEE FOR COPYING THE ENTIRE MEDICAL CHART AND \$10 FEE FOR IMMUNIZATIONS ONLY. PLEASE MAKE CHECKS PAYABLE TO WELLESLEY COLLEGE HEALTH SERVICE.