AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
BY SIMMONS COLLEGE HEALTH CENTER

Patient's name_____
Address_____
Number Street

_____
City State Zip Code Country

Security Number_____ Date of birth_____
Phone number_____ Other name on record, if different_____
School attended: Simmons _____ Other_____ Dates Attended: From_____To_____

I hereby authorize the Simmons College Health Center to release information from my health record to:
Name_____
Organization:_____
Address:_____
_____
Fax number:_____

This authorization covers the following records (please check all you want forwarded)

- ❑ Immunization record
- ❑ PPd (TB) test results
- ❑ My records from treatment of _____only (Please specify diagnosis or symptom)
- ❑ My record for treatment received during the period_____ to _____ (please give dates)
- ❑ Most recent physical exam

The following categories of information will not be released from your medical record without your specific authorization. To authorize release, sign your name next to the categories of information you want released.
Abortion:_____ Mental Health:_____
Pregnancy_____ Sexually Transmitted Disease_____
Sexual assault/incest:_____
HIV test results or information identifying you as having taken an HIV test:_____

This authorization is valid for this request only, and will not be honored for any subsequent requests. This authorization for disclosure (unless expressly revoked earlier) expires 90 days from the date signed by the patient or authorized agent of the patient.

I hereby acknowledge that I have read, or have had read to me, and fully understand the above statements as they apply to me and do voluntarily consent to disclosure.

_____ _____
Patient's Signature Date

Please sign and return this form by fax or mail to the Simmons College Health Center, 94 Pilgrim Road, Boston, MA 02215 Fax: (617) 521-3467