Lesley University

AUTHORIZATION for RELEASE of MEDICAL INFORMATION

Patientôs Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____

I request that my medical records be released to:

Lesley University
Student Health Service
29 Everett St.
Cambridge, MA 02138
Phone: 617.349.8222 Fax: 617.349.8225

Name/Facility information is requested from: _____
Address: _____
State:_____Zip:_____Phone:_____Fax:_____

Information to be released:

Complete Medical History _____
Immunizations and Physical Exam _____
Other: _____
_____

Term: this authorization will remain in effect until:

___ six months from the date of this authorization
___ other: _____

In addition, I have initialed my authorization of the specific categories of information below:

_____ Information about HIV/AIDS status
_____ Information about genetic testing
_____ Information related to confidential communications with a psychiatrist, psychologist, social worker, sexual assault counselor, domestic violence counselor or other mental health professional or human services professional
_____ Information about venereal disease
_____ Information about family planning
_____ Information about treatment of substance abuse (alcohol and/or drugs).

I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby knowingly and voluntarily, authorize disclosure of the above protected health information to the persons or agencies listed above.

_____ _____
(Patient or legal representative signature) Date

_____
(If patient is a minor or incapacitated, indicate representativeôs authority to act on patientôs behalf)