AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

NAME: ____

(Indicate maiden or former name if applicable)

ID# / SS#:______________________ DATE OF BIRTH:______________________

PLEASE FORWARD COPIES OF REQUESTED RECORDS TO:

NAME: University Health Services / Attention: Medical Records Release

University of Massachusetts

STREET: 150 Infirmary Way

CITY, STATE & ZIP: Amherst, MA 01003-9288 FAX: 413-577-5440 VOICE: 413-577-5114

Release the following:

___Entire Health Record ___Immunization Information Only

___Specific Dates of Treatment: From ________ to ________

___Other ____

PURPOSE:

I have an appointment on___/___/___, with________________________________

I hereby authorize and request: NAME:________________________________

STREET:________________________________

CITY,STATE & ZIP________________________________

To send requested information to the address above.

SIGNATURE:________________________________TELEPHONE #____________________

(PATIENT,PARENT OR LEGAL GUARDIAN)

DATE:________________________________WITNESS:________________________________

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the Provider or Facility listed above.

I hereby authorize the Provider or Facility listed above to disclose my medical information as requested. Information used or disclosed by this authorization may be subject to redisclosure by the recipient and no longer be protected by this rule.