UMassAmherst

University Health Services
150 Infirmary Way, Amherst, MA 01003-9288

Medical Records Department
Phone: (413) 577-5114
Fax: (413) 577-5440

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

When completed and signed by you, this form authorizes release of protected information from your clinical record to the recipient designated.

Name: _____ Date of Birth: _____

Address: _____ Student I.D. #: _____

_____ Phone: _____

Affiliation with UMass: ☐ Alum ☐ Former Employee ☐ Other: _____

RELEASE OF INFORMATION SPECIFIED TO:

Name: _____

(Name of provider/facility/individual)

Street: _____

City, State, Zip: _____

Fax Number: _____ Telephone Number: _____

RELEASE THE FOLLOWING INFORMATION:

- ☐ **Entire health record**
- ☐ **Immunization information only**
- ☐ **Information on treatment occurring from _____ to _____**
- ☐ **Other**

☐ If this box is marked, I authorize the release of information regarding diagnosis and/or treatment of AIDS/HIV.

☐ If this box is marked, I authorize the release of information regarding assessment, diagnosis, treatment, and medication used in the treatment of alcohol or substance use disorder. If this box is marked, recipient be aware that: **This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR part 2).** The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug ab use patient.

I REQUEST THAT THIS PROTECTED INFORMATION BE RELEASED FOR THE FOLLOWING REASONS:

_____

☐ This request is being made because I am transferring care to another provider, or leaving the area.

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

This authorization shall remain in effect until _____ (Specify date up to six months)

I hereby authorize University Health Services to disclose my medical information as requested. I may revoke this authorization at any time by sending written notification to UHS at the address on this form. I understand that the revocation will not be effective to the extent that action has already been taken on the authorization. There is no cost to send copies of medical records to another provider, or healthcare facility. Copies for personal use, insurance companies, or legal purposes will be charged a fee.