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

Phone: (413) 577-5114
Fax: (413) 577-5440

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

When completed and signed by you, this form authorizes UNIVERSITY HEALTH SERVICES to obtain information from your clinical record.

Your Name: _____ Date of Birth: _____
Address: _____ Student I.D. #: _____
_____ Phone: _____

University Health Services is Requesting Medical Information From:

Name of Facility or Provider: _____

Street: _____

City/State/Zip: _____

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 Or HIV
- ◯ Please include information in the following categories:
  - ___ Alcohol Abuse
  - ___ Substance Abuse
  - ___ Mental Health Treatment
  - ___ Genetic Testing to screen for possible future health conditions

I request that this protected information be obtained for the following reasons:

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 obtain 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.