Assumption College Student Health Services
500 Salisbury Street, Worcester, MA 01609
Telephone: (508) 767-7329, Fax (508) 767-7102

Consent Form: Authorization to Disclose Health Information

I, _____, authorize Assumption College Student Health Services to **(release ☐ / receive ☐)** a copy of my health information to/from the person and/or entity I have designated below:

Name / Entity: _____

Address: _____

_____

☐ SDCC
☐ Dean of Studies
☐ Residential Life
☐ Buildings and Grounds

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Records to be released:
☐ Summary of Medical Evaluation – date / description: _____
☐ Lab Information – date / description: _____
☐ Immunization Record
☐ Other: _____

Circle preferred method of delivery: Fax Mail Pick-up Verbal

I am requesting that my student health records be released for the following reasons:

☐ Coordinating care between health care providers
☐ Providing an update on my health status
☐ Missing classes
☐ Other: _____

- I authorize all of my student health records to be released ***except*** the following: (be specific about which records you do not want released, for example: specific lab results, specific exam and date, etc.) _____
  _____
- This authorization shall remain in effect until I cease to be enrolled as a student at Assumption College.
- I have a right to revoke this authorization in writing at any time by submitting such written notification to Assumption College Student Health Services. The revocation will not apply to information that has already been released in response to this Authorization.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information.

Student Name: _____ **Date of Birth**: _____ **Class Year:** _____
please print

Student Signature: _____ **Date:** _____ **Cell Phone:** _____

For Office Use: Date Completed: _____ Method of Delivery: _____ Initials: _____