Babson College Health Services
Hollister Hall Suite 130
231 Forest St.
Babson Park, MA 02457
Tel: 781-239-6363
Fax: 781-239-5069

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO BABSON COLLEGE HEALTH SERVICES

Name of Patient: _____

Address _____

_____

Telephone: _____

Date of Birth: _____

**PLEASE CHECK WHICH MEDICAL RECORDS ARE REQUESTED:**

- ❑ Immunization Record
- ❑ Laboratory Results
- ❑ Health History Record
- ❑ Complete Medical Record
- ❑ Medical Visits
- ❑ Other (please specify)_____
- ❑ Gynecological Visits

**RELEASE OF INFORMATION FROM:**

Name of Person or Organization:_____

Address:_____

_____

Phone:_____ Fax:_____

**RELEASE FOR SENSITIVE INFORMATION:**

***I understand that if my medical record contains information in reference to drug and/or alcohol abuse, psychiatric, social services, STDs, HIV/AIDs testing or treatment, hepatitis B testing/treatment and/or sensitive information, I agree to its release.***

Signature of Patient: _____ Date:_____

***I, the undersigned, do hereby authorize the release of my medical information to Babson College Health Services Personnel. I fully understand the nature of this request and authorize the release of information as I have indicated above.***

Signature:_____ Date:_____

Witness Signature: _____ Date:_____

***This authorization is valid for 90 days and may be revoked at any time, in writing, prior to the expiration date.***

Revised 7/25/17