Babson College Health Services
Babson Park, MA 02457
Tel: 781-239-4257
Fax: 781-239-5069

AUTHORIZATION FOR

RELEASE OF MEDICAL INFORMATION TO BABSON COLLEGE HEALTH SERVICES

Name (as it appears on your medical records):____

Address: ____

____

Telephone #: ____

Date of Birth: ____

PLEASE CHECK WHICH MEDICAL RECORDS ARE REQUESTED:

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

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:____________________

FORWARD RECORDS TO:

BABSON COLLEGE HEALTH SERVICE

BABSON PARK, MA 02457

TEL: 781-239-4257…..FAX: 781-239-5069

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

I, the undersigned, do hereby authorize the release of my medical information to be sent to Babson College Health Services. I fully understand the nature of this request and freely give my consent.

Signature: ____ Date:____________________

Witness Signature:_______________________________________ Date:____________________