

Simmons College Health Center

94 Pilgrim Rd. Boston MA 02215

617-521-1020/fax: 617-521-3467

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION PERMISSION TO SHARE INFORMATION

A. Patient's Name (please print):	Date of Birth: ____/____/____
Address:	Telephone Number:

B. Permission to Share: I give my permission to share my individually identifiable health information, which may include protected or privileged information in written and/or verbal form. Please check applicable: ___ Written ___ Verbal

From: Name: _____ Address: _____ _____ Fax Number: _____ Telephone Number: _____	To: Name: _____ Address: _____ _____ Fax Number: _____ Telephone: _____
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C. Reason for Release of Records: _____

D. Information to be released for treatment dates: From ___/___/___ through ___/___/___

E. Documents to be released: Please check YES or NO for each of the following options.

- | | | | | | |
|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|----------------------------|
| YES | NO | | YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Immunization records | <input type="checkbox"/> | <input type="checkbox"/> | Laboratory reports |
| <input type="checkbox"/> | <input type="checkbox"/> | PPD (TB test) results only | <input type="checkbox"/> | <input type="checkbox"/> | Radiology reports |
| <input type="checkbox"/> | <input type="checkbox"/> | Progress notes | <input type="checkbox"/> | <input type="checkbox"/> | Nutrition counseling notes |
| <input type="checkbox"/> | <input type="checkbox"/> | Most recent physical exam | <input type="checkbox"/> | <input type="checkbox"/> | Entire medical record |

F. Privileged or Specifically Protected Information: please check YES or NO for each of the following options.

- | | | | | | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|---|
| YES | NO | | YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental health information, including communication between a patient and a psychiatrist or therapist, at Simmons Counseling Center or off-campus | <input type="checkbox"/> | <input type="checkbox"/> | Eating disorder treatment (including weights) |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Infections | <input type="checkbox"/> | <input type="checkbox"/> | Sexual assault |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS diagnosis and/or treatment | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Abortion |

G. I understand and agree that:

<ul style="list-style-type: none">The information which I authorize for release may be re-sent and no longer protected by federal privacy regulationsI may take back this authorization at any time by notifying the physician/nurse practitioner/Health Center from whom I am requesting this information, provided that the information has not already been released	<ul style="list-style-type: none">This authorization is voluntaryMy treatment will not be conditioned on the completion of this authorizationMy questions about this authorization form have been answered.
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H. This authorization expires 12 months from the date it was signed OR as specified: ___/___/___

If not specified, this authorization will expire 12 months from the date it was received.

X _____ Date ___/___/___
Patient's signature Print name