Simmons University 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:
Email Address:	Year of graduation/departure from Simmons:

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:	**To**:
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Fax Number: _____	Fax Number: _____
Telephone Number: _____	Telephone: _____

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	
☐	☐	Immunization records	☐	☐	Laboratory reports
☐	☐	PPD (TB test) results only	☐	☐	Radiology reports
☐	☐	Progress notes	☐	☐	Nutrition counseling notes
☐	☐	Most recent physical exam	☐	☐	Entire medical record

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

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

G. I understand and agree that:

• The information which I authorize for release may be re-sent and no longer protected by federal privacy regulations • I 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	• This authorization is voluntary • My treatment will not be conditioned on the completion of this authorization • My questions about this authorization form have been answered.

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