

Amherst College Keefe Health Center

95 College Street

Amherst, MA 01002

Phone: (413) 542-2267 / Fax: (413) 542-2647

Authorization to Release or Obtain Medical Records

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cell / home / work

I hereby authorize **Amherst College Health Center** to:

 **Release** information **to:** **Obtain** information **from:**

Name of Person, Provider, Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Method of communication* (check all that apply) Fax Email Mail Talk to (on phone/in person)

For the **purposes** of:

 Continuing care Transfer to new provider Personal use Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

From the **following dates of care**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization expires on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(if no date given, authorization expires 180 days from date below).

Information to be **disclosed**:

 Entire Medical Record Immunization Records Laboratory Reports Radiology Results

 Pathology Reports Office Visit Notes Operative/Procedure Reports Mental Health

 Other (specify portions of medical record requested): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Disclosures Requiring Special Consent** *(complete this section for release of specific privileged information)*

 \_\_\_\_\_\_\_ (initial) HIV/ AIDS: I hereby authorize release of protected health information pertaining to HIV testing and/or diagnosis and/or treatment related to AIDS to the person or organization named above solely for the purpose indicated above.

 \_\_\_\_\_\_\_ (initial) GENETIC TESTING: I hereby authorize release of protected health information pertaining to genetic test results to the person or organization named above solely for the purpose indicated above.

 \_\_\_\_\_\_\_ (initial) ALCOHOL AND DRUG TREATMENT: I hereby authorize release of protected health information pertaining to alcohol and drug treatment to the person or organization named above solely for the purpose indicated above.

I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. Information disclosed under this authorization might be re-disclosed by the recipient, except disclosures requiring special consent, and this re-disclosure may no longer be protected by federal or state law. I have the right to revoke this authorization in writing at any time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Patient or Patient’s Representative Date