Babson College Health Services
Babson Park, MA 02457
Tel: 781-239-6363
Fax: 781-239-5069

AUTHORIZATION FOR

RELEASE OF MEDICAL INFORMATION FROM BABSON COLLEGE HEALTH SERVICES

Name: _____

Address: _____

_____

Telephone #: _____

Date of Birth: _____

SS# or Babson ID#: _____

IMPORTANT

Date that student entered Babson College: _____

Name as it appeared on your Babson College Record: _____

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:

Name:_____

Address: _____

_____

Fax: _____

Tel:_____

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 from Babson College Health Services. I fully understand the nature of this request and authorize the release of information as I have indicated above.

Signature: _____ Date:_____

Witness Signature: _____ Date:_____