WELLESLEY Health Service
Wellesley College
106 Central Street
Wellesley, Massachusetts 02481
(781) 283-2810 Fax: (781) 283-3693

Authorization to Release Medical Records

PATIENT'S FULL NAME: _____
(Indicate maiden/former name, if applicable)

TELEPHONE#:_____**DOB**:_____**CLASS YEAR**: _____

Authorized Release of Protected Health Information

From:

☐ Wellesley College Health Service

☐ Another Provider:
_____
_____

To:

☐ Name, address, telephone, fax
_____
_____
_____

☐ Wellesley College Health Service

Please check information to be released:

_____ Immunization records
_____ Copy of most recent physical exam, including diagnostic test reports (include most recent Pap & Pelvic)
_____ Copies of **ALL MEDICAL RECORDS** from _____ to _____
_____ Other (state specific portions of medical record desired)_____

Unless otherwise revoked this authorization will expire 12 months from date of signature. A copy of this form is available to me upon my request. I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

SIGNATURE: _____ DATE: _____

I understand that my record may contain information in reference to treatment for substance and/or alcohol abuse, psychiatric treatment, sexually transmitted diseases, social service notes, or sensitive information. I agree to its release unless specified otherwise (please explain limitations).

SIGNATURE: _____ DATE _____
Patient/Legal Guardian – Relationship

I understand that my medical record may contain information relating to HIV (AIDS) testing or treatment and I agree to its release.

SIGNATURE: _____ DATE _____
Patient/Legal Guardian – Relationship

THERE IS A $15 FEE FOR COPYING THE ENTIRE MEDICAL CHART AND $10 FEE FOR IMMUNIZATIONS ONLY. PLEASE MAKE CHECKS PAYABLE TO WELLESLEY COLLEGE HEALTH SERVICE.