

**TUFTS UNIVERSITY HEALTH SERVICE
MEDICAL RECORD/INFORMATION RELEASE FORM**

I understand that I may refuse to sign this form and that my refusal to sign will not affect my ability to obtain treatment from Tufts University Health Service. I understand that certain types of sensitive information in my medical record may not be disclosed under federal or state laws without my authorization and that I may revoke my authorization in writing at any time by contacting Tufts University Health Service except to the extent that Tufts University Health Service has taken action in reliance on this authorization. I also understand that if the person or entity that receives my medical information is not required to comply with the federal privacy regulations, the information described below may be redisclosed and would no longer be protected by these regulations. To facilitate my treatment by Tufts University Health Service and other health care providers who may be involved in my care, I hereby authorize the use and/or disclosure of my medical information as follows:

Name (Print) _____
Last First Initial
ID# _____ DOB _____ Yr. Entered _____ Yr. Grad. _____
Phone _____ E-Mail Address _____

PHONE RELEASE

I give permission for the Health Service clinicians or nurses OR _____ to speak to:

My parents (initial) _____ OR to _____

About: My current condition _____ OR _____

Signature _____ Date _____ Exp Date _____

MEDICAL RELEASE FOR TUFTS HEALTH SERVICE RECORDS

I authorize Tufts University Health Service to release the following information:

Initial all that apply:

_____ **All of the information in my general medical record** to include any information relating to sexually transmitted diseases, but excluding information about HIV testing and treatment, psychiatry care, drug/alcohol abuse, and sexual assault mental health counseling.

_____ Only the following specific information: _____

_____ HIV/AIDS testing or treatment records.

_____ Psychiatry records

_____ Alcohol and/or drug abuse records

Release the information to:

Check here if you will personally pick up records.

Name (Print) _____ Fax _____

Address _____ Phone _____

Signature _____ Date _____ Exp. Date _____

TO OBTAIN RECORDS FROM PREVIOUS PROVIDERS

I give permission to release the following information (include dates if necessary) from:

Name of physician or medical facility: _____

Address _____

Street

City/State/Zip

Phone _____ Fax # _____

To: Tufts University Health Service, 124 Professors Row, Medford, MA 02155

Phone (617) 627-3350 Fax (617) 627-3592

Attention: _____

Specific Information: _____

Signature _____ Date _____