EASTERN CONNECTICUT STATE UNIVERSITY HEALTH SERVICE

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____, authorize the release of the following information

FROM / TO:

Eastern CT State University
Health Services
185 Birch Street
Willimantic, CT 06266
Phone: 860-465-5263
Fax: 860-465-4560

FROM / TO:

_____
_____
_____
_____
Phone: _____
Fax: _____

_____ Complete health record (excluding mental health, HIV or alcohol/substance related records. These will only be released if specifically indicated below.)

_____ Most recent physical examination _____ Immunization records

_____ Mental health records _____ Laboratory results (Date(s): _____

_____ HIV/AIDS related information

_____ Alcohol and/or substance abuse treatment information

_____ Other information (specify): _____

Purpose of Disclosure:

_____ School admission requirements _____ Employment requirement

_____ Continuing treatment _____ Other: _____

I understand that I have the right to inspect and receive copies of the information to be disclosed. I have the right to revoke this consent at any time. Revoking this consent shall have no effect on any disclosures made before the revocation. Any revocation must be submitted in writing and signed. This authorization expires 90 days after it is signed or upon the following date, event, or condition: _____.

_____ _____
Eastern Student ID # Date of Birth

_____ _____
Signature Date of Request

_____ _____
Signature of Witness Date

For Health Service Use Only:

Date completed: _____ By: _____

(HS-Rev.1/09)