EASTERN CONNECTICUT STATE UNIVERSITY STUDENT HEALTH SERVICE

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____, authorize the release of the following information

FROM / TO: *(Please circle one)*	**FROM / TO:** *(Please circle one)*
Eastern CT State University Student Health Services 185 Birch Street Willimantic, CT 06266 Phone: 860-465-5263 Fax: 860-465-4560	_____ _____ _____ _____ 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 examination _____ Immunization records

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

_____ HIV/AIDS related information

_____ Alcohol and/or substance abuse treatment information

_____ Information pertaining to a specific condition, or to specific dates of treatment. (*Please specify*): _____

_____ Other information (*Please specify*): _____

Purpose of Disclosure:

_____ School admission requirements _____ Employment requirement

_____ Continuing treatment _____ Other: (Specify) _____

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: _____

(SHS-Rev.2/2012)