Please Note
If you are a **varsity athlete** also contact Athletics' Clinical Liaison since you may have additional records on file with Athletics

Please Note
Turn Around Time For Medical Records Is Between 7-10 Days

Boston College
Health Services Rm. 005
140 Commonwealth Ave. Chestnut Hill, MA 02467
Tel: 617 552-3225 Fax: 617 552-1671

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Step 1: Information about you:

Name:_________________________________ Other names (maiden)_______________________ Date of Birth:_______________
Last First MI
Address:____ BC ID#____________________
Street City State Zip

Tel (cell) number:_________________________ Fax:_______________________ E-mail:_________________ Student Status: O Undergrad O Graduate O Transfer O Evening Year started:_____________ Year Graduated:___________

Step 2: To whom do you wish to release your records to:

Name of Person/Facility, Address, Phone or fax number as applicable

____

____

____

Release the following Information:

O **Entire Medical Record** O **Immunizations only** O **Other**:________ **Specific Dates: From__________to __________**

Step 3: Authorization and Signature

I hereby authorize_______________________________________ to release the records as described above. This authorization is valid for 90 days and may be revoked in writing at any time, except to the extent that action has already been taken in response to this authorization. I also release BC health Services from any liability or legal responsibility in connection with the release of the above information. I do not give permission for any other use or re-disclosure of this information.

I also accept the risk and consequence of faxing medical records.

Patient Signature **Guardian Signature(if under 18)** **Witness** **Date**

Step 4: Release for Sensitive Information

I understand that if my medical record contains information in reference to drugs and/or alcohol abuse, psychiatric, venereal disease, social service, Hepatitis B testing/treatment and/or sensitive information, **I agree to the release of this information, with my signature and date on the lines below.**

Patient Signature **Date**

Step 5: Release of HIV Information

In addition to the above signatures, if you want your HIV (AIDS) testing/treatment records released, **I agree to the release of this information, with my signature and date on the lines below.**

Patient Signature **Date**

Below is for BC Use Only

Date Received:_______ Date Sent:________ Initial:______ Mailed:_______ Fax:_______ Pick up:________