RELEASE

Authorization for Release of Information Form

I, _____, authorize Suffolk University Health Services, 73 Tremont Street, Boston, MA 02108.
to ***release*** protected health information to the person and/or agency I have designated below.

Name	_____	Date of birth	_____
Address	_____		
City	_____	Telephone	_____
State	_____ Zip _____	Fax	_____

Circle preferred Method to be sent: Mail
Fax
Pick-up

I request that the following protected health information be released: (be specific about what you want released – everything, immunizations, specific lab results, last exam, etc.)

_____

_____

I have the right to revoke this authorization, in writing, at any time by sending such written notification to Health Services.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of your personal information and no longer protected by HIPPA Privacy Rule.

_____ _____
(Signature of Patient) (Date)

If a personal representative of the client signs this authorization, a description of such representative's authority must accompany this authorization.