HUSSON UNIVERSITY STUDENT HEALTH SERVICES

Release of Health Information Request Form

In order to receive copies of your medical records please complete this form and fax to 207.941.7866. *Please allow 7 business days to fulfill this request.*

Your Information:

Last Name: _____ First Name: _____
Date of Birth: ____/____/____ Student ID# _____
Campus: _____ Last Date of Attendance: _____
Telephone #: (_____)_____-_____ Email: _____
Address: _____ City: _____ State: ____ Zip: _____

I request that Husson University Student Health Services and its authorized employees to release/receive/discuss my Protected Health Information (medical records) to/from:

Name: _____
Address: _____
Phone: _____ Fax: _____

Information to be released is as follows (please check all that apply):

☐ Immunization History
☐ Lab Reports
☐ Mental Health Screening & Treatment
☐ Progress Notes Related to: _____
☐ Complete Progress Notes
☐ Complete Medical Records

The purpose of this release is for: _____
(examples: continued care, school admission, legal, personal)

- I (DO/ DO NOT) authorize release of information related to the diagnosis and treatment of Mental Health disorders.
- I (DO/ DO NOT) authorize release of information related to the diagnosis and treatment of HIV infection, AIDS related Complex (ARC), or AIDS.
- I (DO/ DO NOT) authorize release of information related to the diagnosis and treatment of Alcohol and/or drug abuse.

Student Signature: _____ Date: _____

Please note: this form is not valid without a signature and date.

Office Use Only:
Request Received _____ | Request Sent_____ | Initials_____