

NORTHEASTERN UNIVERSITY HEALTH AND COUNSELING SERVICES
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

STATUS: () CURRENT NU STUDENT () GRADUATED NU STUDENT: YEAR: _____
() GRADUATED NEC STUDENT: YEAR: _____

NAME: _____ DATE OF BIRTH: _____

STUDENT ID (if applicable): _____

**** (include all ID numbers issued while attending Northeastern University) ****

PHONE#: _____

I, _____, hereby authorize University Health and Counseling Services
(student/patient or legal representative) Northeastern University
Forsyth Building, Suite 135
360 Huntington Avenue
Boston, MA 02115-5000

to release information from the record of person named above to:

Information to be released is for the time period from _____ to _____ and includes:

Complete Record X-Ray Results Laboratory Results Consultation Reports

Other: _____

This authorization does not apply to release of the following information without my specific consent in the space below: (*INITIAL* all categories that apply):

____ HIV testing ____ sexual assault ____ pregnancy testing
____ AIDS/HIV Infection ____ domestic violence ____ abortion
____ Substance Abuse ____ sexually transmitted disease ____ mental health
____ Other: _____

This information release is for the purpose of: _____.

Signed: _____ Relationship: _____ Date: _____
(signature of patient/student or legal representative)

Witness: _____ Date: _____

- This authorization expires 90 days from the date it is signed or upon completion of _____.
- I understand that I have the right to revoke this authorization in writing addressed to the Correspondence Clerk, University Health and Counseling Services, 70 Forsyth Street, Boston, MA. University Health and Counseling Services will honor the revocation **unless good faith action has already been taken in reliance on this authorization.**
- I understand that I have a right to receive a copy of this authorization.

NORTHEASTERN UNIVERSITY HEALTH AND COUNSELING SERVICES

MEDICAL RECORD REQUEST

Name: _____ Date of Birth: _____ Soc. Sec. #: _____

I, _____ hereby authorize _____

to release information from the medical record of _____.

Information is to be released to: University Health and Counseling Services
Northeastern University
Forsyth Building, Suite 135
360 Huntington Avenue,
Boston, MA 02115-5000

Information to be released is for the time period from _____ to _____ and includes:

- Medical Record Abstract (consisting of Discharge Summary, if applicable, Clinical Resume, if applicable, History and Physical, if applicable, Operative Reports, if applicable, Pathology Reports, if applicable, X-Ray Reports, if applicable, Other Imaging Reports, if applicable, Laboratory Reports, if applicable, Diagnostic Test Results, if applicable, Consultants Reports, if applicable.)
- Other: _____

This authorization does not apply to release of the following information without my specific consent in the space below: (*INITIAL* all categories that apply:

____ HIV Testing	____ Sexual Assault	____ Pregnancy Testing
____ AIDS/HIV Infection	____ Domestic Violence	____ Abortion
____ Substance Abuse	____ Sexually Transmitted Diseases	____ Mental Health
____ Other: _____		

This information release is for the purpose of: _____.

Signed: _____ Relationship: _____ Date: _____
(Signature of patient/student or legal representative)

Witness: _____ Date: _____

- This authorization expires 90 days from the date it is signed or upon completion of _____
- I understand that treatment may not be conditioned on signing an authorization.
- I understand that I may revoke this authorization in writing and that the revocation will be honored **unless good faith action has already been taken in reliance on this authorization**
- I understand that information released may be re-released by the recipient and may, therefore, no longer be covered by the Privacy Rule.
- I understand that I have a right to receive a copy of this authorization.