FITCHBURG STATE UNIVERSITY
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Fitchburg, MA 01420
Tel: (978) 665-3216 Fax: (978) 665-3641
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Student Health Services

Authorization for Release of Medical Records

Step 1 Complete □	Patient Name: _____ DOB: _____ Address: _____, City/State: _____ Telephone:_____ ID/SS#: _____ • **What year did you arrive at FSU? _____. Are you a current student? Y or N** • **What year _____ did you *Graduate ( ); *Withdraw ( ); or *Transfer ( )** • **Were you ever a patient in Health Services? ( ) YES or ( ) NO**
Step 2 Completed □	***I AUTHORIZE: STUDENT HEALTH SERVICES, FITCHBURG STATE UNIVERSITY***
Step 3 Completed □	**To release the following medical information:** □ History & Physical Exam □ Operative Report □ Treatment Report □ Consultation Report □ X-ray Report □ Laboratory Tests □ Immunizations other:_____ _____ in regards to healthcare received from: _____ to: _____ (date) (date)
Step 4 Completed □	To: _____ (Name of Institution / Health Care Provider) _____ _____ (Address) (City, State, Zip Code) Tel: # _____ Fax: # _____ for the purpose of: _____
Step 5 Completed □	This authorization will expire in six (6) months from the date signed and may be revoked at any time in writing prior to the expiration date not to be retroactive to the original release date. I release the facility and its employees from any liability or legal responsibility that may arise from this authorization. _____ _____ (Signature of patient or legal guardian) (Signature of witness)
Step 6 Completed □	I authorize that this may include information relating to: Yes No Yes No □ □ AIDS or HIV □ □ Psychiatric care □ □ Sexually transmitted diseases □ □ Social Services □ □ Treatment for alcohol and/or drug abuse _____ _____ **(Signature of patient or legal guardian** **(Signature of witness)** _____ _____ Date Date