

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

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

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

**Step 1: Information about you:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First MI Other names (maiden)  
Address: \_\_\_\_\_ BC ID# \_\_\_\_\_  
Street City State Zip  
Tel (cell) number: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_ Student Status:   
Undergrad  Graduate  Transfer  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:**

Entire Medical Record  Immunizations only  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: \_\_\_\_\_