Division of Student Life and Academic
Development · Student Health Service ·
29 Everett Street, Cambridge, MA 02138
Phone 617.349.8222 Fax 617.349.8225

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION
LESLEY UNIVERSITY STUDENT HEALTH SERVICE

Patient's Name:_____ Date of birth:_____

I authorize Lesley University Student Health Service to disclose and/or use the above named individual's health information as described below.

- Person/Organization receiving the information: Name:_____

  Address:_____

  Phone#_____Fax#_____

- Description of specific information to be disclosed and/or used (include dates of service)

  _____

  _____

- Purpose for disclosure of information:_____

  _____

I understand that this authorization is voluntary. I need not sign this form in order to ensure treatment, enrollment or eligibility for health services rendered to me. I may inspect a copy of the information to be used and/or disclosed.

I understand that if the organization receiving the information is not a health plan or health care provider, the released information might no longer be protected by Federal privacy laws and might be re-disclosed by the recipient without my authorization.

I understand that I have a right to revoke this authorization in writing to the Student Health Service at any time unless it has already been acted on, and that such revocation will not affect my treatment, enrollment or eligibility for services rendered to me.

I knowingly and voluntarily authorize Lesley University Student Health Service to disclose and/or use the health information specified in the manner described above.

SIGN HERE: _____ Date: _____
(Patient or legal representative signature)

If patient is not signing, indicate representative's authority to act on patient's behalf: _____