SUFFOLK
UNIVERSITY

SUFFOLK UNIVERSITY HEALTH & WELLNESS SERVICES

Authorization for Release of Medical Information

I, _____, authorize Suffolk University Health & Wellness Services, 73 Tremont Street, Boston, MA 02108 to ***release*** a copy of my health records to the person and/or entity I designate below:

Name/Entity: _____

Address:

_____

_____

City: _____

State: _____ Zip: _____ Telephone: _____Fax: _____

Circle preferred Method to be sent:

Mail
Fax
Pick-up

I authorize all of my health records to be released ***except*** the following: (be specific about which records you do not want released, for example: specific lab results, specific exam and date, etc.)

_____

_____

_____

I have the right to revoke this authorization in writing at any time by submitting such written notification to Suffolk University Health & Wellness Services.

Student Name (please print): _____D.O.B._____ SuffolkID:_____

Student Signature: _____Date:_____