

Student Health Records Request/Release Authorization

Section 1 – Student Information

Name:	Banner ID:
Date of Birth:	Phone #:

Section 2 – Disclosure

I, the undersigned, authorize Brown University to Release to / Request from/ Verbally communicate with/

Name:	Address:
Phone #:	Fax #:

For the following purpose/proposed use:

Consultation Treatment Claim Settlement Other (please explain): _____

The following health records:

All Information **OR** The following limited information: Appointment History Last Note/Summary
 Other (please specify condition and/or treatment dates): _____

In my (select only the department(s) whose record you need released): Student Health Services record SHARE record
 BWell Health Promotion record Counseling and Psychological Services (CAPS) record Athletic Training record

Except for: Mental health Genetic testing Drug or alcohol use Sexually transmitted infections
 Gender Identity history/information HIV-related information, including testing Sexual and Interpersonal violence history

Section 3 – Method of Transmission

Please use the following method of record transmittal:

Fax Digitally via a protected/encrypted email (specify email): _____
 Mail X-Ray Portal
 I, the student/patient, will pick up personally Verbal communication

Section 4 – Authorization: Please only enter a date in the space below IF you want the release to expire sooner than the standard 180 days.

I certify that this request has been made voluntarily and that the information given above is complete and accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time in writing, except to the extent that action has already been taken to comply with it. This Authorization will expire one (1) year from the date signed, unless earlier revoked by me in writing or an alternate date is specified here: _____

A facsimile or photocopy of this Authorization shall be considered as effective and valid as the original. I hereby release Brown University, its employees and agents, from any liability to me or anyone claiming by, through, or under me, which may arise directly or indirectly out of the University's good faith compliance with this Authorization.

I have read this Authorization prior to signing and I understand its contents.

Signed: _____	Dated: _____
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Relationship to Student: Self Other: _____

For Brown University Student Health and Wellness use only:

Fax Health domain Mail Picked Up Dicom Date: _____ Initials: _____