Health and Wellness
Box 1928
Providence, RI 02912
Phone: 401-863-3953
Fax: 401-863-7953

Medical Records Request/Release Authorization

Section 1 – Student Information

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

Section 2 – Disclosure

I, the undersigned, authorize Brown University to ☐ release to / ☐ request from

Name:	Address:
Phone:	Fax:

The following medical records:

☐ **All information** OR **The following limited information:**

☐ Appointment history
☐ Last note/summary
☐ Other (please specify by stating condition and/or treatment and dates): _____

_____

In my:

☐ Health Services record ☐ BWell Health Promotion record ☐ SHARE record
☐ Counseling and Psychological Services (CAPS) record ☐ Athletic Training record

Except for:

☐ mental health
☐ drug or alcohol use
☐ sexually transmitted infections
☐ sexual and interpersonal violence history
☐ genetic testing
☐ gender identity history/information
☐ HIV-related information, including testing

For the following purpose/proposed use:

☐ Consultation ☐ Treatment ☐ Claim Settlement ☐ Other:

Section 3 – Method of Transmittal

Please use the following method of record transmittal:

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

Section 4 – Authorization

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. Without my express written revocation, this Authorization will automatically expire upon satisfaction of the need for disclosure, but in any event on the earlier of _____(date), or 180 days from the date below. A facsimile or photocopy of this Authorization shall be considered as effective and valid as the original. I hereby release Brown University, its employee 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:

Relationship to Student: ☐ Self ☐ Other:

For Brown University Health and Wellness use only:

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