BROWN

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

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 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 (select only the department(s) whose record you need released)**:** ☐ 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 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: 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:

Relationship to Student: ☐ Self ☐ Other:

For Brown University Health and Wellness use only:

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