



New England Conservatory Health Center

290 Huntington Avenue, SB Room 112
Boston, MA 02115

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the **New England Conservatory Health Center**
to release a copy of my medical record or a specified portion thereof to:

Name: _____

Address: _____

I authorize this release with the understanding that it may include information in one or more of the following categories:

- Initial all sections** below to **verify** your willingness to release information to above individuals
- Cross out** all that you **do not wish** to be released to above individuals

- _____ Immunization Records
- _____ NEC Health Report
- _____ Information relating to alcohol or drug abuse treatment
- _____ Information acquired by social workers consulted by the patient in their professional capacity
- _____ Information relating to sexually transmitted diseases
- _____ Communication between the patient and psychotherapists related to the patient's mental or emotional condition
- _____ Communication between a patient and a sexual assault or domestic violence counselor regarding a sexual assault or domestic violence.

Name of Patient: _____
(my name)

Address: _____

Date of Birth: _____ NEC ID Number: _____

Medical Information Requested: _____

Purpose of request: _____

Signature of Patient or Legal Guardian

Print name & relationship if other than patient

Date

ADDITIONAL AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORD INFORMATION INCLUDING THE RESULTS OF HIV ANTIGEN OR ANTIBODY TESTING

The specific information to be disclosed is as initialed above.

I have authorized release of any and all medical records including, but not limited to information regarding the history of or the treatment for **SEXUALLY TRANSMITTED DISEASE** and/or any record of or results of HIV testing, and/or any record of treatment for AIDS.

I understand that the medical record contains information about testing for the HIV antibody or antigen. I do herein expressly and voluntarily consent to disclosure of the medical record information for the purpose or need stated above. I further understand that I am not giving permission for any redisclosure other than specified above. I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance thereon.

Signature of Patient or Legal Guardian

Print name & relationship if other than patient

Date

Please Note: This authorization for release of medical record information (unless expressly revoked earlier) expires six (6) months after the above date, except to the extent that the disclosing party has already acted in reliance on it. Any information added to the record after the date of authorization cannot be sent until an updated authorization is received.