

Brandeis University Health Center

415 South Street MS 034

Waltham, MA 02454

(781)736-3677 FAX (781)736-3675

Authorization for Release of Medical Information

Name _____

Please include previous name if applicable

Address _____

Number & Street Address

_____ Date of Birth _____

City

State

Zip

mm/dd/yy

SS# _____ Daytime Phone (____) _____

Are you a current student? _____ or indicate year(s) of attendance _____

I authorize _____

Provider / facility you are requesting information from

Address _____

Phone (____) _____ Fax (____) _____

Please release the following medical information:

Immunization Record __

Lab Report/s __ (please specify) _____

Other __ (please specify) _____

Choose {
One {
Only {

____ Please send requested information to me by: Mail __ Fax __ Pick up __
or
Fax (____) _____
____ Please send information to: (complete this section)

Name _____

Address _____

Phone (____) _____ Fax (____) _____

Please indicate by: Mail __ Fax __

Signature (Required)

Date

All fields must be completed. Please allow up to 72 business hours to process your request.