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

Phone (_____)_____ Are you a current Brandeis Student? Yes ☐ No ☐

Alumni, when did you attend Brandeis? e.g. 2012-2016 _____

I authorize _____
Provider or facility you are requesting information from (e.g. Brandeis Health Center)

Address _____

Phone (_____)_____ Fax (_____)_____

Please release the following medical information:

☐ Immunization Record (includes Titers, TB testing, CXR Reports, if available)

☐ Lab Report/s (please specify) _____

☐ Other (please specify) _____

☐ _____ Include All Sensitive Material or Limited to ☐ _____
(please initial) (e.g. Recent Pap only)

Please send requested records to me by: ☐ Mail ☐ Pick up ☐ Fax (_____)_____

☐ Email (Immunization records only) Important: Email is not considered a secure method.

☐ Please send requested records to: (complete this section)

Name _____

Address _____

_____

Phone (_____)_____ Fax (_____)_____

Please indicate by: Mail ☐ Fax ☐ Phone Conversation ☐

_____ _____
Signature (Required) Date

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