

PINE MANOR COLLEGE
Health and Wellness Center

400 Heath Street
Chestnut Hill, MA 02467

Telephone: (617) 731-7171
FAX: (617) 731-7559

CONSENT FOR THE RELEASE OF MEDICAL INFORMATION

Instructions: The patient must complete this form in its **entirety** in order for the Health & Wellness Center to release any medical information. The patient must be specific as to the nature of the information she would like released and the purpose for which it is requested.

I authorize Pine Manor College Health and Wellness Center to release my medical records pertaining to _____
(Specific information to be released)

accumulated during the period beginning _____ and ending _____ for purpose of
(mo/da/yr) (mo/da/yr)

TO: _____
(Name of individual or agency)

ADDRESS: _____

Telephone # _____ Fax # _____

This information is for use by the recipient named above only. Under the Family Education and Privacy Act of 1974, this information cannot be given to any other individual or agency without the patient's consent.

Patient's Name (print) _____ **Patient's Signature** _____

Name while a student at Pine Manor College, *if different from above:* _____

Address _____

Telephone # _____ Soc.Sec # _____ Date of Birth _____

Dates of attendance at Pine Manor College: From: _____ To: _____

Today's Date: _____ (This authorization will expire one year from this date)

Mail request to above address - attention Director of Health Services.