MIDDLESEX Community College
BEDFORD • LOWELL

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1-800-818-3434 • www.middlesex.mass.edu

STUDENT INFORMATION

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Student ID# A00_____

Preferred Phone #: _____ E-mail address: _____

Address: _____ City: _____ State: _____ Zip: _____

RECORDS TO BE RELEASED FROM

Name:

Address: _____

Phone and/or Fax Number: _____

RECORDS TO BE RELEASED TO

Name: _____

Address: _____

Phone Number: _____

☐ Please **Fax** to: _____

I authorize the following portions of my medical record to be released:

☐ All Records
☐ Immunizations
☐ Last physical
☐ All test results
☐ Other: _____ *(please specify)*

THIS AUTHORIZATION IS SUBJECT TO REVOCATION AT ANY TIME
Except to the extent that disclosure made in good faith has already occurred. Revocation must be made in writing.

Student's Signature _____ Date: _____

Legal Representative: _____ Relationship:_____

If student is unable to sign, signature of person authorized and relationship to student

Witness: _____ Date: _____

RETURN COMPLETED FORM TO ➔

Student Information Center
Lowell **Cowan Center-3rd Floor**
33 Kearney Square-Lowell MA 01852

Fax: 978-656-3421
RECORDS@middlesex.mass.edu

Student Information Center
Bedford Enrollment Center 1st Floor
591 Springs Road- Bedford MA 01730

Fax: 978-656-3421
RECORDS@middlesex.mass.edu

FOR OFFICE USE ONLY

☐ Records to be **mailed** to name and address listed above
☐ Records to be released to Student
☐ Records to be **faxed** to name and address listed above
Staff Initials: