NHTI
Concord's Community College

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

Please complete form thoroughly. Copies of your medical record cannot be released until this form is complete, signed by the student or legal guardian (if under age 18)

1. Name _____ DOB _____ Phone _____
2. Student ID # _____ Last date attended: _____
3. What was/is your program of study (Major) _____
4. Release Method: ___ Personal pickup ___ Mail ___ Fax ___ email ____verbal
5. Who do you wish to release your **records to**: **Name** _____

   _____

   Address **Phone** **Fax or email**

   Who do you wish to obtain your **records from**: **Name** _____

   _____

   Address **Phone** **Fax or email**
6. Release the following information: _____ entire medical record _____ immunization information

   The following specified information: _____

Authorization and Signature:

I hereby authorize NHTI Concord's Community College Health Services Staff to release the records as above. This authorization is valid for one (1) year and may be revoked (except retroactively) at any time in writing prior to the expiration date. I do not give permission for any other use or re-release of this information.

I release NHTI Health Services from all legal responsibility or liability that may arise from the act I have authorized above.

_____ _____

Student Signature **Date**

Release of Protective Health Information

IF INFORMATION TO BE RELEASED INCLUDES ANY OF THE INFORMATION DESCRIBED BELOW, you must initial those that apply below

_____sexual assault records _____ sexually transmitted disease records _____ HIV/AIDS test

I hereby authorize NHTI Health Service Staff to release all information in such records as initialed above

_____ _____ _____ _____

Student Signature **Date** **Witness Signature** **Date**