NEC Health and Counseling Services

Authorization for Release of Medical Information

( ) Current Student

( ) Date graduated _____

NEC ID# _____

Name _____ Date of birth _____

Address _____

Phone _____ Email _____

I, _____, hereby authorize NEC Health and Counseling Services

to release information from my medical record for the time period from_____ to

_____ including any pertinent information (such as testing results, immunization

record, etc) regarding _____

from my medical record to: _____.
(name **and** address **or** fax **and** phone number)

This authorization **does not apply** to release of the following information **unless I have initialed** any of the following categories -- no initials mean no information to be sent:
___ HIV testing ___ AIDS/HIV infection ___ sexually transmitted disease
___ Sexual assault ___ pregnancy testing ___ pregnancy termination
___ domestic violence ___ substance abuse ___ mental health
___ other _____

Name _____ Signature _____ Date _____
(please print)

This authorization expires 90 days from date signed.