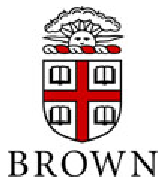

Brown University Student Support Services
Release of Information Form

Most of the attached "Release of Information Form" has been pre-filled by the Clearance Committee.

Please fill in the following items:
Section 1 - Student Information: Complete all 4 fields
Section 2 – Disclosure: Check off your required clearance type(s): Health Services and/or CAPS
Section 4 – Authorization: Complete all fields. Signature required, typed names cannot be accepted.

Health and Wellness
Box 1928
Providence, RI 02912
Phone: 401-863-3953
Fax: 401-863-7953

Medical Records Request/Release Authorization

Section 1 – Student Information

Name:	ID#:
Date of Birth:	Phone#:

Section 2 – Disclosure

I, the undersigned, authorize Brown University to ☐ release to / ☐ request from

Name:	Address:
Phone:	Fax:

The following medical records:
☐ **All information** OR **The following limited information:**
☐ Appointment history
☐ Last note/summary
☐ Other (please specify by stating condition and/or treatment and dates): ____________

In my:
☐ Health Services record ☐ BWell Health Promotion record ☐ SHARE record
☐ Counseling and Psychological Services (CAPS) record ☐ Athletic Training record

Except for:
☐ mental health ☐ genetic testing
☐ drug or alcohol use ☐ gender identity history/information
☐ sexually transmitted infections ☐ HIV-related information, including testing
☐ sexual and interpersonal violence history

For the following purpose/proposed use:
☐ Consultation ☐ Treatment ☐ Claim Settlement ☐ Other:

Section 3 – Method of Transmittal

Please use the following method of record transmittal:

☐ Fax	☐ Digitally via a protected/encrypted email
☐ Mail	☐ X-ray Portal
☐ I, the student/patient, will pick up personally	☐ Verbal communication

Section 4 – Authorization

I certify that this request has been made voluntarily and that the information given above is complete and accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time in writing, except to the extent that action has already been taken to comply with it. Without my express written revocation, this Authorization will automatically expire upon satisfaction of the need for disclosure, but in any event on the earlier of _______(date), or 180 days from the date below. A facsimile or photocopy of this Authorization shall be considered as effective and valid as the original. I hereby release Brown University, its employee and agents, from any liability to me or anyone claiming by, through, or under me, which may arise directly or indirectly out of the University's good faith compliance with this Authorization.
I have read this Authorization prior to signing and I understand its contents.

Signed: ____________________________ Dated:
Relationship to Student: ☐ Self ☐ Other:

For Brown University Health and Wellness use only:
☐ Fax ☐ Health domain ☐ Mail ☐ Picked Up ☐ Dicom Date: ____________ Initials:

Revised 6/20

SAMPLE

If you have any questions about this form, please send an email to studentsupport@brown.edu.
Please submit the completed form via email: studentsupport@brown.edu or fax: 401-863-1999

Student Support Services
Box 2015 | Providence, RI 02912
Phone: 401-863-3145 Fax: 401-863-1999
Email: studentsupport@brown.edu Web: http://brown.edu/student-support

Health and Wellness
Box 1928
Providence, RI 02912
Phone: 401-863-3953
Fax: 401-863-7953

Medical Records Request/Release Authorization

Section 1 – Student Information

Name:	ID#:
Date of Birth:	Phone#:

Section 2 – Disclosure

I, the undersigned, authorize Brown University to ☒ release to / ☐ request from

Name: Student Support Services	Address: 69 Brown Street, 5th Floor, Box 2015, Providence, RI 02912
Phone: 401-863-3145	Fax: 401-863-1999

The following medical records:

☐ **All information** OR **The following limited information:**

☐ Appointment history
☐ Last note/summary
☒ Other (please specify by stating condition and/or treatment and dates): ______________
The content of the letter written by my home provider for the purpose of returning from leave.

In my:

☐ Health Services record ☐ BWell Health Promotion record ☐ SHARE record
☐ Counseling and Psychological Services (CAPS) record ☐ Athletic Training record

Except for:

☐ mental health ☐ genetic testing
☐ drug or alcohol use ☐ gender identity history/information
☐ sexually transmitted infections ☐ HIV-related information, including testing
☐ sexual and interpersonal violence history

For the following purpose/proposed use:

☐ Consultation ☐ Treatment ☐ Claim Settlement ☒ Other: *Leave return process*

Section 3 – Method of Transmittal

Please use the following method of record transmittal:

☐ Fax	☒ Digitally via a protected/encrypted email
☐ Mail	☐ X-ray Portal
☐ I, the student/patient, will pick up personally	☒ Verbal communication

Section 4 – Authorization

I certify that this request has been made voluntarily and that the information given above is complete and accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time in writing, except to the extent that action has already been taken to comply with it. Without my express written revocation, this Authorization will automatically expire upon satisfaction of the need for disclosure, but in any event on the earlier of ________(date), or 180 days from the date below. A facsimile or photocopy of this Authorization shall be considered as effective and valid as the original. I hereby release Brown University, its employee and agents, from any liability to me or anyone claiming by, through, or under me, which may arise directly or indirectly out of the University's good faith compliance with this Authorization.
I have read this Authorization prior to signing and I understand its contents.

Signed: ______________________________________ Dated:

Relationship to Student: ☐ Self ☐ Other:

For Brown University Health and Wellness use only:

☐ Fax ☐ Health domain ☐ Mail ☐ Picked Up ☐ Dicom Date: ______________ Initials: