Northeastern UHCS
University Health and Counseling Services
www.northeastern.edu/uhcs

135 Forsyth Building-- 617-373-2772 (phone) -- 617-373-2601 (fax)

Since all your medical records are strictly confidential, you must provide us with a written request specifying information desired and where you wish it to be sent. The following forms must be mailed or faxed to:

University Health and Counseling Services
Northeastern University
Forsyth Building, Suite 135
360 Huntington Avenue
Boston, MA 02115-5000
Fax: 617-373-2601

This request of information (ROI) must include:

- your name and address
- telephone number and e-mail address
- NU ID number
- dates attended (including when you left and whether or not you graduated)
- your signature

When you have graduated, send us a ROI and we'll send your records to the office of your new primary care practitioner.

Please allow **AT LEAST TWO (2) WEEKS** to process the request. If there is an urgent need for medical records for clinical care, please call us at (617) 373-2772, to let us know the request must be expedited.

NORTHEASTERN UNIVERSITY HEALTH AND COUNSELING SERVICES
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

STATUS: ( ) CURRENT NU STUDENT ( ) GRADUATED NU STUDENT: YEAR: _____

NAME: _____ DATE OF BIRTH: _____
NU ID # (if applicable): _____
****(include all ID numbers issued while attending Northeastern University)****
PHONE #: _____

I, _____, hereby authorize
(student/patient or legal representative)

University Health and Counseling Services
Northeastern University
Forsyth Building, Suite 135
360 Huntington Avenue
Boston, MA 02115-5000

to release information from the record of person named above to:

_____
_____
_____
_____

Information to be released is for the time period from_____ to _____ and includes:

□ Complete Record □ X-Ray Results □ Laboratory Results □ Consultation Reports

□ Other: _____

This authorization does not apply to release of the following information without my specific consent in the space below: (*INITIAL* all categories that apply):

___ HIV testing	___ sexual assault	___ pregnancy testing
___ AIDS/HIV Infection	___ domestic violence	___ abortion
___ Substance Abuse	___ sexually transmitted disease	___ mental health

___ Other: _____

This information release is for the purpose of: _____.

Signed: _____ Relationship: _____ Date: _____
(signature of patient/student or legal representative)

Witness: _____ Date: _____

□ This authorization expires 90 days from the date it is signed or upon completion of _____.
□ I understand that I have the right to revoke this authorization in writing addressed to the Correspondence Clerk, University Health and Counseling Services, 70 Forsyth Street, Boston, MA. University Health and Counseling Services will honor the revocation **unless good faith action has already been taken in reliance on this authorization.**
□ I understand that I have a right to receive a copy of this authorization.

NORTHEASTERN UNIVERSITY HEALTH AND COUNSELING SERVICES
MEDICAL RECORD REQUEST

Name:_____ Date of Birth:_____ NU ID #:_____

I, _____hereby authorize _____
_____
_____
_____

to release information from the medical record of _____.

Information is to be released to:

University Health and Counseling Services
Northeastern University
Forsyth Building, Suite 135
360 Huntington Avenue,
Boston, MA 02115-5000
Fax: 617-373-2601

Information to be released is for the time period from _____ to _____and includes:

□ Medical Record Abstract (consisting of Discharge Summary, if applicable, Clinical Resume, if applicable, History and Physical, if applicable, Operative Reports, if applicable, Pathology Reports, if applicable, X-Ray Reports, if applicable, Other Imaging Reports, if applicable, Laboratory Reports, if applicable, Diagnostic Test Results, if applicable, Consultants Reports, if applicable.)

□ Other:_____

This authorization does not apply to release of the following information without my specific consent in the space below: (*INITIAL* all categories that apply:

___ HIV Testing	___ Sexual Assault	___ Pregnancy Testing
___ AIDS/HIV Infection	___ Domestic Violence	___ Abortion
___ Substance Abuse	___ Sexually Transmitted Diseases	___ Mental Health
___ Other:_____		

This information release is for the purpose of:_____.

Signed:_____ Relationship:_____ Date: _____
(Signature of patient/student or legal representative)

Witness: _____ Date: _____

□ This authorization expires 90 days from the date it is signed or upon completion of _____
□ I understand that treatment may not be conditioned on signing an authorization.
□ I understand that I may revoke this authorization in writing and that the revocation will be honored **unless good faith action has already been taken in reliance on this authorization**
□ I understand that information released may be re-released by the recipient and may, therefore, no longer be covered by the Privacy Rule.
□ I understand that I have a right to receive a copy of this authorization.