

UMASS MEMORIAL HEALTH
AUTHORIZATION TO DISCLOSE
STUDENT PROTECTED HEALTH INFORMATION
BY UMASS MEMORIAL MEDICAL CENTER - STUDENT HEALTH SERVICES

HealthAlliance-Clyinton Hospital
Marlborough Hospital
UMass Memorial Health - Harrington Hospital
UMass Memorial Medical Center
UMass Memorial Medical Group | Location: _____

NAME: _____
BIRTHDATE/AGE: _____
SEX: _____
MEDICAL RECORD NUMBER: _____
HAR / CSN ACCOUNT NUMBER: _____
PRINT CLEARLY IN INK OR APPLY PATIENT LABEL

I, _____, hereby authorize
UMass Memorial Medical Center • Student Health Services (Student Health Services), its employees and/or agents to release
the following protected health information that it currently has or may have in the future: Immunization Information (which may
include titer results), Tuberculosis Clearance, History and Physical Exam Records (including lab reports and diagnostic test results
that I have provided to Student Health Services), and Chest X-Rays.

I authorize the release of this information to: any of the clinical/rotation site(s) of the UMass Chan Medical School (UMCMS),
Tan Chingfen Graduate School of Nursing, and Morningside Graduate School of Biomedical Science (collectively referred to in this
authorization as UMCMS/TCGSN/MGSBS) and non-UMCMS affiliated clinical/rotation site(s) that I am or will be assigned to as a
student of UMCMS/TCGSN/MGSBS, the Clinical and/or Rotation Coordinators for UMCMS/TCGSN/MGSBS, the
UMCMS/TCGSN/MGSBS Clerkship Directors, the UMCMS/TCGSN/MGSBS Travel Coordinators, and the designated
UMCMS/TCGSN/MGSBS school representatives for compliance.

The purpose of this authorization is to allow for the sharing of information to verify that I meet all communicable disease clearance
requirements. I understand that if I do not authorize this information to be provided to clinical or rotation sites, the site may refuse to
allow me to rotate within their facility.

This authorization will expire when I am no longer a student at UMCMS/TCGSN/MGSBS, unless I revoke it before such time.
I have the right to revoke this authorization at any time by submitting this request in writing to Student Health Services by email to
studenthealth@umassmemorial.org.

I understand this authorization is voluntary, and I do not need to sign it to receive treatment.

I understand any disclosure carries the potential for unauthorized re-disclosure. I release UMass Memorial Health and its entities
from any legal liability that may arise from the disclosure or re-disclosure of this information.

I have read and understand the above statements and authorize the disclosures requested in this form.

Student Signature _____

Printed Name _____

Date _____

Time _____

Please submit this completed form to Student Health Services via Peoplesoft Portal.

