| UMASS MEMORIAL HEALTH | | |
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| AUTHORIZATION TO DISCLOSE STUDENT PROTECTED HEALTH INFORMATION BY UMASS MEMORIAL MEDICAL CENTER - STUDENT HEALTH SERVICES | an a | |
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| HealthAlliance-Clinton Hospital Marthorough Hospital | an an an Anna Anna Anna Anna Anna Anna | |

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

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 authozation 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 an 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.

NS FCM 0030 Most Recent Review Date: 04/15/22

