CHP Health Center
Phone #: (413) 528-8580   Fax #: (413) 528-8583

AUTHORIZATION FOR REQUEST OF MEDICAL INFORMATION

We are required by law to obtain your written permission to request your medical/dental information.

Patient's Name:____ **Date of Birth:**_____________

Address:____ **Phone #:**_________________

City, State, ZIP:____

I authorize the following provider or Facility to release the indicated portions of my medical records to the Community Health Center of the Berkshires. Reason for Release:

Medical Information needed for East Coast Prep program file

Provider or Facility Name:____
PHONE #:____
Address:____
City, State, Zip:____

X Immunizations **X** Last Physical **X** Other **Current Medication List**

(Please include dates if applicable):____

Please send records to:

East Coast Prep
P.O. Box 940
Great Barrington, MA 01230

Patient's Signature:____ **Date:**_________________

Legal Representative:____ **(60 day expiration)**
(If patient is under the age of 18, must be signed by a parent or legal representative)

Witness:____ **Date:**_________________

All my records may be release except the following:

❑HIV testing ❑AIDS related information ❑Alcohol abuse and/or treatment
❑Drug abuse and/or treatment ❑Psychiatric Evaluation and/or treatment ❑Sexually transmitted diseases

Patient's Signature:____ **Date:**_______________

Legal Representative:____ **(60 day expiration)**
(If patient is unable to sign, signature of person authorized and relationship to patient)

This authorization is subject to revocation at any time