STCC
Springfield Technical Community College

One Armory Square
Suite 1 • PO Box 9000
Springfield, MA 01102-9000
(413) 781-7822 • www.stcc.edu

Health and Wellness Center · Building 19, Room 177 · Phone (413) 755-4230 · Fax (413) 755-6045

Authorization To Obtain Health Records

This form is available online at: www.stcc.edu/healthservices
Please allow two business days from the date of receipt for processing.

1. Print your Information

Name: _____ **STCC ID#:** _____

Address: _____ **Date of Birth:** _____

2. Choose where to Obtain your records

☐ I hereby authorize Springfield Technical Community College (STCC) to **obtain** health information from:

Name: _____ **Phone:** _____

Address: _____ **Fax:** _____

3. Choose what information to share

Please select the information to be obtained or disclosed (check all that apply):

- ☐ Records of immunity and tuberculosis screening
- ☐ Physical Exam Records
- ☐ Medical Evaluation Records
- ☐ Drug Screening Results
- ☐ Professional licenses and certifications
- ☐ Permission to discuss/share patient health information

4. Read and Sign

This authorization will be in effect for the duration of your enrollment at STCC. You have the right to revoke this authorization, or limit the information released, at any time.

If you have any questions regarding this release of information, please contact the Health and Wellness Center at (413) 755-4230. The signed and dated form must be returned to the Health and Wellness Center.

I have read the above statements and am aware and agree to the sharing of my information with/from the individual/organization named above.

_____ (signature) _____ (date)

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Authorization To Release Health Records

This form is available online at: www.stcc.edu/healthservices
Please allow two business days from the date of receipt for processing.

1. Print your Information

Name: _____ **STCC ID#:** _____

Address: _____ **Date of Birth:** _____

2. Choose where to Release your records

☐ I hereby authorize Springfield Technical Community College (STCC) to **release** health information to:

Name: _____ **Phone:** _____

Address: _____ **Fax:** _____

3. Choose what information to disclose

Please select the information to be obtained or disclosed (check all that apply):

- ☐ Records of immunity and tuberculosis screening
- ☐ Physical Exam Records
- ☐ Medical Evaluation Records
- ☐ Drug Screening Results
- ☐ Professional licenses and certifications
- ☐ Permission to discuss/share patient health information

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_____ _____
(signature) (date)