



Department of Health Services • Building 20, Room 320 • Phone (413) 755-4230 • Fax (413) 755-6045

Medical Records Release Form

This form is available online at: www.stcc.edu/healthservices

PLEASE COMPLETE THE FOLLOWING INFORMATION:

NAME:

Form line for name with labels (last), (first), (middle), (maiden)

STUDENT ID OR SSN:

Form line for student ID or SSN

LAST YEAR ATTENDED STCC:

Form line for last year attended STCC

DATE OF BIRTH:

Form line for date of birth

PHONE NUMBER:

Form line for phone number

ADDRESS:

Form line for address

NAME OF AUTHORIZED INDIVIDUAL TO RECEIVE, AND ADDRESS TO SEND MEDICAL RECORDS

Form lines for authorized individual name and address

I, HEREBY GIVE SPRINGFIELD TECHNICAL COMMUNITY COLLEGE PERMISSION TO RELEASE A COPY OF MY MEDICAL RECORD TO THE ABOVE LISTED INDIVIDUAL:

(Signature)

(Date)

ALLOW ONE WEEK FOR PROCESSING.

THERE IS A \$1.00 FEE FOR ALL RECORDS THAT ARE MAILED.