CAPE COD COMMUNITY COLLEGE
Powerful Futures Start Here

Office of the Registrar - Cape Cod Community College - Student Immunization Records
2240 Iyannough Road, West Barnstable, MA 02668
1-508-362-2131 Ext. 4331 / Fax 508-375-4039 / sthompson@capecod.edu

# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

*Your health information is confidential and protected by state and federal laws. The information you submit is maintained by Cape Cod Community College Student Immunization Records Office in the strictest confidence.* ***HIPAA*** *regulations prevent us from releasing or discussing any health information without written consent of the patient, except when there is imminent danger to you or to others, or when required by law.*

Last Name: _____ First Name: _____ Student ID #: _____

Other Name(s) (if different from above): _____ Date of Birth: (mm/dd/yyyy) _____

SSN: _____ Phone: _____ Dates of Attendance: _____

Address: _____ City: _____ State: _____ Zip: _____

Permission is hereby given for Cape Cod Community College **Student Immunization Records Office** to release the information specified below from the medical record to:

_____

_____

_____

_____

Telephone: _____ Fax: _____

**I understand that the information to be released may include information protected by federal and state laws. By my signature below, I authorize the disclosure and/or discussion of the following checked information:**

☐Complete Health Record ☐Immunization Record ☐Physical Exam ☐Laboratory Report(s)

**METHOD OF RELEASE AUTHORIZED: (Check all that apply)**

- ☐ Permission to fax
- ☐ Student/Authorized 3rd Party picks up information in person
- ☐ Information sent by mail
- ☐ Verbal / Telephone

**THIS AUTHORIZATION IS VALID FOR THE DURATION OF THE ABOVE NAMED STUDENT'S ENROLLMENT AT CAPE COD COMMUNITY COLLEGE FROM THE DATE OF SIGNATURE. THIS AUTHORIZATION WILL BECOME NULL AND VOID UPON THE STUDENT'S SEPARATION FROM THE COLLEGE.**

I understand that I may revoke this consent in writing at any time, except to the extent that action has already been taken in response to this authorization. I also release the Cape Cod Community College Student Immunization Records Office from any liability or legal responsibility in connection with the release of the above information.

Student Signature: _____ Date: _____

**For Student Immunization Records Office Use:**

Date Completed: _____ # of Pages Copied: _____ Staff Initials: _____