Records Request/Release Consent and Authorization

Section 1 – Student/Patient Information

Name:	Student ID Number:
Date of Birth:	Phone Number:

Section 2 - Disclosure

I, the undersigned, authorize Brown University to ☐ release to / ☐ request from

Name:	Address:
Phone:	Fax:

The following information and/or records:

☐ Information regarding my:
    ☐ educational records
    ☐ cognitive or mental health

☐ drug or alcohol use or treatment
☐ treatment, testing, and monitoring

For the following purpose/proposed use:
☐ aiding my medical school studies and educational planning
☐ other: _____

Section 3 – Method of Transmittal

Please use the following method of record transmittal:

☐ Fax: _____	☐ E-Mail: _____
☐ Mailed to the address in Section 2	☐ Phone: _____
☐ I, the student/patient, will pick up personally	

Section 4 – Consent and Authorization

I certify that this request has been made voluntarily and that the information given above is complete and accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time in writing, except to the extent that action has already been taken to comply with it. Without my express written revocation, this Authorization will automatically expire upon satisfaction of the need for disclosure, but in any event on the earlier of _____ (date), or 180 days from the date below. A facsimile or photocopy of this Authorization shall be considered as effective and valid as the original. I hereby release Brown University, its employee and agents, from any liability to me or anyone claiming by, through, or under me, which may arise directly or indirectly out of the University's good faith compliance with this Authorization.

I have read this Consent and Authorization prior to signing and I understand its contents.

Signed: _____	Dated: _____
Relationship to Student: ☐ Self ☐ Other:	