

MEDICAL INFORMATION RELEASE FORM

Name _____ ID# _____ Date of Birth _____
(Please Print) Last Name, First Name Middle Initial Month/Day/Year

Best phone # _____ Best email address _____

Address _____
Street City State Zip Code

As a patient, you may review and/or request a copy of medical information contained in your medical record. You must complete this form. This only applies to the medical information indicated below.

Please indicate, by checking the appropriate box(es), the specific information you are requesting.

- Immunization Records Review Medical Information w/provider
 PPD Results Lab Results (specify) _____
 Entire Medical Record Medical Information/Record for _____
 Other _____ Specify dates

Please indicate how you would like to obtain this medical information.

- I will pick up Please mail to: _____ Please fax _____
Indicate below Area code/Fax number

I authorize the Howard University Student Center to send a copy of my medical information (requested above):

To _____
Name of person (Physician, Health Care Provider) to receive information

Address _____
Street City State Zip Code

Phone Number _____
Area Code/Phone Number Area Code/Fax Number

I authorize the Howard University Student Center to obtain a copy of my medical information (Please specify the information you are requesting) _____

From _____
Name of person (Physician, Health Care Provider) to release information

Address _____
Street City State Zip Code

Phone Number _____
Area Code/Phone Number Area Code/Fax Number

To be mailed or faxed to: Howard University Student Health Center
2139 Georgia Avenue, N.W.
Washington, DC, 20059
(Phone) 202-806-7540 (Fax) 202-806-7416

Signature of student or personal representative _____ Date _____ If personal representative, relationship to student _____

FOR OFFICE USE ONLY

Date process initiated _____ Initial _____

Reviewed by (Initial/date) _____

Date Requisition Completed (Initial/date) _____ Date released _____ Initial _____