Howard University Student Health Center~2139 Georgia Avenue, N.W. ~Washington, DC, 20059
202-806-7540 (phone) ~ 202-806-7416 (fax)

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
- □ PPD Results
- □ Entire Medical Record
- □ Other____________________
- □ Review Medical Information w/provider
- □ Lab Results (specify)________________
- □ Medical Information/Record for____________ Specify dates

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

□ I will pick up □ Please mail to: ______________________ (Indicate mailing information below) □ Please fax ________________ Area code/Fax number

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□ 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

Started Processing on (date):_______________________________ **Initials:** ____________________

Reviewed by (Initials): ____________________________ **Date:** __________ **APPROVED:** □ **YES** □ **NO**

Date Processing Completed: __________ **Initials:** __________ **Date Information released** __________ **Initials:** ________

SHC 4/05-01(Revised 3/10)