

HOWARD UNIVERSITY STUDENT HEALTH CENTER 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

Current Student: Yes No Health Science Program: Yes No Graduated (yr) _____

Cell phone # _____ 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 and sign this form. This request only applies to the medical information indicated below.

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

- | | |
|---|---|
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Entire Medical Record |
| <input type="checkbox"/> PPD Results (if < 1yr may pick up; if > 1 yr will mail or fax to medical office) | <input type="checkbox"/> Review Medical Information w/provider |
| <input type="checkbox"/> Lab Results (specify) _____ | <input type="checkbox"/> Medical Info/Records for _____
<small>Specify dates</small> |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Health Clearance |

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

- I will pick up Please mail Please fax Please indicate mailing/faxing information below.

- I authorize the Howard University Student Health Center to MAIL and/or FAX a copy of my medical information / records as 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 (Print Your Name) _____ hereby authorize the Howard University Student Health Center to obtain a copy of my medical information and/or medical records. Please specify the information and dates 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

Please Mail or FAX to: Howard University Student Health Center
2139 Georgia Avenue, N.W.
Washington, DC, 20059
(Phone) 202-806-7540 (Fax) 202-806-7416

PLEASE ALLOW 3 DAYS FOR THIS REQUEST TO BE PROCESSED.

STUDENT SIGNATURE or personal representative _____ Date _____ if personal representative, relationship to student / Date _____

FOR OFFICE USE ONLY

Received by (Initials/date): _____ Reviewed by (Initials): _____ Date: _____ APPROVED: YES NO

Comments: _____

Date Information released _____ Initials: _____