



CONSENT TO RELEASE MEDICAL RECORDS

Patient name:
Date of birth:
Student ID #:

Telephone Numbers:
Cell:
Home/Other:

I hereby authorize and request that
Name of facility/individual
Address
City/State/Zip

Release information from my records to the following: fax number, if applicable

Name of the facility/individual:
Address
City/State/Zip

Please be specific regarding record and dates requested fax number, if applicable

Information to be released:

- Diagnosis and record of treatment
Laboratory and/or X-ray reports
Immunization/ TB test record
Entire file (excluding confidential and psychiatric records, if any)
Other

I understand that upon my request, I will be given a copy of the information released. I also understand that there will be a small processing fee for the copy I personally receive. I give my consent to the release of above-mentioned information and understand that my consent is subject to revocation at any time. This ROR will expire 60 days after the date of the signature.

Patient signature Date

Student Health and Counseling Services Use Only

- ID verification by
Faxed (date/time) Mailed certified/return receipt (date)
BCA Records given to patient / date and time Educator's approval
Records given to patient / date and time Provider's approval
Patient will pick up approximately on: Patient paid / date

Revised 05/08