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):

☐ Immunization Records
☐ PPD Results (If < 1yr may pick up; If > 1 yr will mail or fax to medical office)
☐ Lab Results (specify)_____
☐ Other_____
☐ Entire Medical Record
☐ Review Medical Information w/provider
☐ Medical Info/Records for_____ Specify dates
☐ 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: _____

SHC 4/05-01(Revised1/11) CHART COPY (WHITE) STUDENT COPY (YELLOW)