

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Check Appropriate Box

PURPOSE FOR THIS REQUEST: (CHECK ONE) ☐ Healthcare ☐ Insurance Coverage ☐ Personal
☐ Transfer of Care ☐ Legal ☐ Other

☐ **Fax**ROI-7/12cp

ADMINISTRATIVE:

To be completed by an employee of the Student Health Service

Date Request Received: _____ Received by: _____

Circle One: Records Mailed Records Picked Up Records Faxed Records Denied

Charge: _____ Correspondence Received: _____

Employee Signature: _____ Date Request Completed: _____