Becker College Health Services

Medical Records Release Authorization

Name_____Date of Birth_____

Address_____City _____State_____Zip_____

Home phone_____Work phone_____

_____I hereby authorize Becker College Health Services to release the following medical record information **TO:**

Facility/Doctor's Name:_____ City/State:_____ Phone #: _____ Fax #:_____

Self: □

_____I hereby authorize Becker College Health Services to request the following information **FROM**:

Facility/Doctor's Name:_____ City/State:_____ Phone #: _____ Fax #:_____

************Please indicate information you wish request and/or release*************

_____Immunization Records _____Physical Exam

_____Lab Reports (specify) _____Complete Record

_____Other (specify)_____
_____

For the purpose of_____

I understand that this authorization is only valid 30 days from date of signature. This information will be released to the party indicated above following receipt of properly signed and dated authorization.

Signatures:

Student_____Date_____

Parent/Guardian_____Date_____
(If student is under 18 yrs old)

Witness_____Date_____
