

Anderson University Health Services
Department of Student Life
Medical Record Release Authorization Form

To: Anderson University Health Services
From:

- Student Name: _____
- Student Permanent Address: _____
- Student Permanent Phone Number: _____
- Student Campus Address and Box Number: _____
- Student Social Security Number: _____ - _____ - _____

I _____ hereby authorize and request Anderson University Health Services to release copies of my entire Anderson University Health record to:

(Name and address of agency...include fax number if possible)

Student Signature Authorizing Request

Date of Request

Witness Signature

HEALTH SERVICES OFFICE USE ONLY:

Records sent via:

U.S. Mail (date)

Faxed (date)

Other (date)

Health Services Employee Signature