Rice University Student Health Service

RECORD RELEASE AUTHORIZATION

Release records *from*: ____

Physician or Hospital

____

Address/Telephone/Fax

I hereby request and authorize you to release:

___ The following tests or records: __________________________________

___ Complete medical record- I understand that I am not required to release genetic testing or counseling results.

Release the above information *to*:

____

Physician or Hospital

____

Address/Telephone/Fax

The release is good for sixty days unless I revoke it by writing before such time.

Name: ___________________________ Maiden Name: _________________

Date of Birth: ___/___/___

Address: ____

Signature: ______________________ Date: ___/___/___

Witness: ________________________

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