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: _____________________________

Mark Jenkins, M.D. ® Stacy Ware, M.D. ® Jessica McKelvey, M.D.

6100 Main Street ® MS- 760 ® Houston, Texas 77005 ® 713-348-4966 Fax 713-348-5427