Rice University Student Health Services
Authorization to Release Medical Records

Name: ______________________________________ Date of Birth: ____/____/____
(Last Name, First Name, Maiden Name)

Phone#: (___)___________________

Signature of Patient or Legal Represntative: _____________________________ *Date:* __________

****NOTE: If mailing or faxing this form, please include a copy of your photo ID****

- By signing this form, I authorize: ____Rice University Student Health Services____
  Organization that is to realease information

  6100 Main Street ____________ Houston, TX 77005 __ 713-348-4966 __ 713-348-5427
  Address **City/State/Zip** **Phone#** **Fax#**

- To disclose to: ____
  Person or Organization that is to receive information

  ____
  Address **City/State/Zip** **Phone#** **Fax#**

METHOD OF RELEASE (Check One): Mail ____ Fax ____ Pick-up ____

Please release the following information (be specific):

___ Immunization Record

___ Lab Work

___ Radiology Reports

___ Office Visit (dates: ______________)

_____ Other: _____________________

_____ Complete Medical Record

Jessica McKelvey, M.D. Kelly Castro, M.D. LeCresha Peters, M.D.

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