RICE UNIVERSITY
Student Health Services

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please complete and sign this form and include a copy of a valid photo ID. Completed documents may be submitted by email or fax.

STUDENT INFORMATION

Name: _____

Last Name, First Name, MI

Student ID: _____ **Date of Birth:** _____ / _____ / _____

REQUESTED RECORDS

Please release the following information (*Select one*):

- ◯ Immunization Record
- ◯ Lab Work
- ◯ Radiology Reports
- ◯ Office Visit (date): _____
- ◯ Complete Medical Record
- ◯ Other: _____

RELEASE METHOD

(*Select one*): ◯ Fax ◯ Mail ◯ Pick-up ◯ SHS Portal*

**Access to the SHS Health Portal is only available to students active in Summer 2025 and beyond.*

The records may be released to the following person(s) or organization:

_____

Person(s) / Organization Name

_____

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

By signing this Authorization for Release of Medical Records, I authorize Rice University Student Health Services ("Releasor"), located at 6100 Main Street, Houston, Texas 77005, phone: 713-348-4966, fax: 713-348-5196, to release my medical records as described above.

_____ Date: _____ / _____ / _____

Signature of Patient or Legal Representative

OFFICE USE ONLY: _____ _____

Processed By: *Date*