Wake Forest University Student Health Service P.O. Box 7386 Winston-Salem, North Carolina 27109 336-758-5218 FAX 336-758-6054

MEDICAL RECORD INFORMATION RELEASE FORM

1.	Name of Individual:	(Last)	(First)	(Middle)
2.	WFU ID #:	Birth Date:			Cell Number:
3.	Circle A or B.		MO DAY	Y YR	
the		lays for records to be cop sed information be kept co		that the WF	U Student Health Service release information, with
	Provide address w	here records can be maile	d if not picke	d up within 5	5 days:
	(Name)				
	(Addres	ss)			
(City)			(State)		(Zip)
	B. I request that information be released to WFU Student Health Service from:				rom:
	(Name)				
	(Addres	ss)			
	(City)		(State)		(Zip)
4.	HIV, Mental Health	and Drug and Alcohol in authorization unless othe	aformation co	ontained in t	the parts of the records indicated above will be release: Drug & Alcohol(initials)
5.	Reason for release of in	nformation:			
un tha the	derstand that I may re at has already been rele e date of this signed rel	voke this authorization eased. This authorizatio	at any time n will remai	in writing. n valid until	ation and to the above specified parties. I also The revocation will not apply to information I revoked or upon expiration of one year from
	y Whom:				