

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

I. Name of Individual:

(Last) (First) (Middle)

2. WFU ID #: _____ Birth Date: _____ Cell Number: _____
MO DAY YR

3. Circle A or B.

A. **Allow 2 business days for records to be copied.** I request that the WFU Student Health Service release information, with the stipulation that the released information be kept confidential, to:

Provide address where records can be mailed if not picked up within 5 days:

(Name)

(Address)

(City) (State) (Zip)

B. I request that information be released **to** WFU Student Health Service from:

(Name)

(Address)

(City) (State) (Zip)

4. Describe portion of record or specific information to be released: _____

HIV, Mental Health and Drug and Alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.

Do not release:

_____ HIV testing _____ Mental Health (Psychiatric) _____ Drug & Alcohol
(initials) (initials) (initials)

5. Reason for release of information: _____

Signature: _____
Date: _____
Witness: _____

Date Sent/Given: _____
By Whom: _____