Medical Record Release form

*I hereby authorize **Wesleyan College Health Services** to release the indicated information:*

_____ _____
Patient's Name Date of Birth

_____Office Visit
_____Lab/X-ray
_____History & Physical
_____Immunization Records
_____Insurance
_____Other (specify)_____

Please release the information marked above to:

Name: _____

Fax: _____

Phone: _____

I understand that I may withdraw this authorization with written notice, except to the extent that action has already been taken place.

Signed:_____ Date
Student signature *(Parent or Guardian's signature if under age 18)*

Witness:_____Date_____

Wesleyan College Health Services
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Phone (478) 757-4025
Fax (478) 757-4027