

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Roger Williams University Health Service

One Old Ferry Road

Bristol, Rhode Island 02809

Phone: 401-254-3156 Fax: 401-254-3305 Scan: klebreux@rwu.edu

Please Print

Name: _____ Other names (i.e. maiden): _____

Date of Birth _____ last 4 digits of SS# _____

Address _____

Phone _____ Date of last semester attending RWU _____

I authorize _____ fax/phone _____
to release the following information:

____ Immunization record

____ Lab / radiology results from (dates) _____

____ Other specific information regarding _____

_____ (dates) _____

____ Entire record (Fee of \$15 for copy of entire record to be paid prior to release)

Release information TO:

Name: _____

Address: _____

Phone: _____ Fax: _____

Signature of person requesting release of information / or legal guardian if under 18:

I hereby ____ consent ____ refuse to the release of confidential information concerning mental illness, alcohol and /or drug use, sexually transmitted disease, AIDS or HIV test results, if any.

Print name: _____

Signature: _____ Date: _____

Revocation: I understand that I may revoke this authorization at any time by requesting such in writing, unless action has already been taken.

Term of authorization: Fulfillment of this request, one (1) year, or date specified.
Specific date: _____