WRIGHT STATE UNIVERSITY

STUDENT BENEFITS OFFICE

051D STUDENT UNION

3640 COLONEL GLENN HIGHWAY

PHONE: 937.775.2553 FAX: 937.775.3260

MEDICAL RECORD REQUEST/RELEASE AUTHORIZATION

Name: _____ Student UID#: _____

Date of Birth: _____/_____/_____ Phone Number: _____-_____-_____

MM DD YYYY

( ) I hereby authorize WSU Student Benefits to request my health record from:

( ) I hereby authorize WSU Student Benefits to release my medical information to: (via postal service)

( ) I hereby authorize WSU Student Benefits to release my medical information to: (via fax)

Name: _____

Address: _____

Phone: _____-_____-_____ Fax: _____-_____-_____

For the purpose of: ( ) Consultation ( ) Treatment ( ) Claim Settlement ( ) Other

Please check **ONLY ONE** option below:

( ) Release all information in my medical record

( ) Release ONLY the following specified information: (specify illness and/or treatment, labs, immunization records, etc.)

_____

_____

Signed: _____ Date: _____/_____/_____

Signature of Patient (or legal guardian if under the age of 18) MM DD YYYY