



WASHINGTON DC
STUDENT HEALTH SERVICE

AUTHORIZATION FOR RELEASE OF PSYCHIATRIC RECORDS

Print Name: Last	First	MI	Social Security # / GW @ #
Address	City	State	ZIP
Date of Birth	<input type="checkbox"/> Current student	<input type="checkbox"/> Former student	Phone (Monday to Friday, 9AM to 5PM)
	First semester registered at GWU: _____	()	
	Last semester registered at GWU: _____		

I, the undersigned, request and authorize: Student Health Service
 The George Washington University
 2141 K Street, NW #501
 Washington, DC 20037
 Phone: 202-994-6827 Fax: 202-973-1572

To Provide to: To Receive From:

Name: _____

Address: _____

Phone: _____

The following information: <input type="checkbox"/> Psychiatric Records: <input type="checkbox"/> All <input type="checkbox"/> Limited to visit(s) on: _____ <input type="checkbox"/> Other: _____ This information is required for the purpose of: _____ _____

Please:
 Mail
 Hold for Pick Up on _____

Charges to send information from GWU Student Health:
 * Partial Psychiatric Record (1 page) \$ 5.00
 * Psychiatric Record (Complete) \$16.00
 * Psychiatric Record for students with exit date
 prior to Fall 2000/3rd party request \$32.00

* Please allow 7 to 10 days for this request.
 * Make checks payable to: George Washington University

Patient Signature _____ Date _____

* * * FOR OFFICE USE ONLY * * *	
Copied: SHS Initial _____ Date _____	<input type="checkbox"/> Mailed <input type="checkbox"/> Picked up: SHS Initial _____ Date _____