



WASHINGTON DC
STUDENT HEALTH SERVICE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Print Name: Last	First	MI	Social Security # / GW ID
Date of Birth mm/dd/yyyy	<input type="checkbox"/> Current student <input type="checkbox"/> Former student <input type="checkbox"/> School of Medicine/HealthSc	First semester registered at GWU: _____ Last semester registered at GWU: _____ Phone (Mon-Fri, 9AM to 5PM): _____	

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:
 ** Fees apply **

To Receive From:
 ** Fees do not apply **

Name: _____

Address: _____

Phone: _____ **Fax:** _____

The following information:	<input type="checkbox"/> Immunization/Partial Medical Records (1 page) - \$5.00 (** Immunization records reflect compliance with DC Immunization Law)
	<input type="checkbox"/> All Medical Records (students who graduated Fall 2000 or later) - \$10.00
	<input type="checkbox"/> All Medical Records (students who graduated prior to Fall 2000) - \$20.00
	<input type="checkbox"/> Limited to visit on: _____
	<input type="checkbox"/> Other: _____
This information is required for the purpose of: _____	

Please:
 Mail
 Fax (Immunization Records only)
 Hold for Pick Up on _____

Please allow **2 business days** for this request.
Make checks payable to: The George Washington University

Credit Card Payments:
Card # _____
Expiration Date ____ / ____
Zip Code of Billing Address _____

Patient Signature _____ **Date** _____

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