University of the District of Columbia
University Health Services
4200 Connecticut Ave N.W.
Building 44 ~ Suite A 39
Washington, DC 20008
Telephone (202)274-5030
Confidential Fax (202)274-5411

UNIVERSITY OF THE DISTRICT OF COLUMBIA 1851

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient name [Please Print]	Student ID #	Date of Birth

Date of Request

I hereby authorize _____ to release to the **University Health Services** of the University of the District of Columbia the following requested medical information.

☐ MEDICAL RECORD ☐ IMMUNIZATION RECORD

Recipient [Please print]	Street Address
Fax #	State/Zip
Patient Signature	Patient Telephone
Parent/Guardian Signature [If patient under age 18]	Patient Street Address
Date	Patient State/Zip

Please fax information to UDC University Health Services: ATTN: Student Health Coordinator
Phone: (202) 274-5030
Confidential Fax: (202) 274-5411

Revised 09/2014