



# BIOLA UNIVERSITY

## STUDENT HEALTH CENTER

### AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, (name) \_\_\_\_\_ hereby give permission for the release of the following information from my medical records.

- Most recent Physical Exam, with all lab results included
- Most recent Mantoux TB test (Chest X-Ray report if result positive)
- All immunization records
- All Cardiology test reports
- Most recent Pap Smear (pathology & labwork)
- All Medical Records from date \_\_\_\_\_ to \_\_\_\_\_
- Other: \_\_\_\_\_

**TO:**  **FROM:**

DR: \_\_\_\_\_

CLINIC: \_\_\_\_\_

PH # \_\_\_\_\_

FAX # \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

**TO:**  **FROM:**

BIOLA UNIVERSITY STUDENT HEALTH CENTER  
13800 BIOLA AVENUE, LA MIRADA, CA 90639  
PH 562-903-4841 FAX 562-906-4512

**PARENT**

NAME \_\_\_\_\_

PH # \_\_\_\_\_

FAX # \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

**TO: PATIENT IN PERSON**

DATE \_\_\_\_\_

**Signature of person** authorizing release of records:

\_\_\_\_\_

Date of Birth or Student ID \_\_\_\_\_

Phone: \_\_\_\_\_

Date of last semester attended \_\_\_\_\_