WHITTIER
1887
COLLEGE

Health Services

Authorization for Release of Patient Information

Whittier College
Student Health Services
13612 Philadelphia Street
Whittier, CA 90608
Phone: (562) 464-4548
Fax: (562) 464-4511

Patient Name _____ **Date _____**
Date of Birth _____ **Student ID # _____**

I request and authorize:

Provider's Name: _____

Address: _____

Phone #: _____ Fax: _____

To release health care information of the patient named above to:

Whittier College Student Health Services

Address: 13612 Philadelphia Street, Whittier, CA 90608

Phone: (562) 464-4548 Fax: (562) 464-4511

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above-named patient.

Material(s) Requested

- ☐ Physical Exam
- ☐ PAP Smear
- ☐ Labs, please specify which test(s): _____
- ☐ Radiographic view, please specify: _____
- ☐ TB Skin Test
- ☐ Specific Vaccine(s), please list: _____
- ☐ All Vaccination Records
- ☐ All Medical Records
- ☐ Other: _____

I authorize the release of these records as indicated and certify that I am the patient above. I understand that there may be sensitive information within these records regarding my health.

Signature: _____ Date: _____

Initials of Office Personnel Taking Information: _____

Records were:

- ☐ **Faxed** **Date: _____**
- ☐ **Mailed** **Date: _____**
- ☐ **Picked up in person** **Date: _____**