AMERICAN UNIVERSITY
WASHINGTON, DC

STUDENT HEALTH CENTER
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Print Name: Last First MI AUID Number

Address

City State Zip Code

Date of Birth _____ ☐ Current Student ☐ Former Student Last semester at AU_____

Current Phone Number: _____

I, the undersigned, request and authorize:

American University
Student Health Center
4400 Massachusetts Avenue, NW
Washington, DC 20016
Phone: 202.885.3380 Fax: 202.885.1222

☐ To Release To ☐ To Request From:

Name: _____

Address: _____

_____

Phone: _____ Fax:_____

The following information: ☐ Immunization Records (Submitted in Compliance with DC immunization Law)
☐ All Medical Records ☐ Records limited to visit date: _____

Please (circle one) MAIL FAX HOLD FOR PICK UP

Charges to duplicate your medical record:

Immunization/Partial Medical Record (1 page)	$1.00 per page up to 10 pages
Entire Medical Record	$15.00 for any record longer than 10 pages

Please Note: Records will not be sent without payment.

I authorize and request for my sole benefit the release of medical information which is a part of my file in the Student Health Center at The American University. This does not constitute blanket permissions for release of such information for an infinite period of time but is limited to this instance only. I understand that my records can be picked up by me in person, faxed, or sent via US Mail. I hereby completely and fully release and discharge American University of any and all liability for furnishing the information requested.

Patient Signature:_____ Date:_____

FOR OFFICE USE ONLY

COPIED: Initial__ Date_____ Mailed Faxed Picked Up Date Initial