Wesleyan University: Davison Health Center
327 High St. Middletown, CT 06459
P: 860-685-2470 F:860-685-2471

Authorization For Release of Medical Information

Student Name: _____ Date of Birth _____

Wes ID: _____ Class Year: _____ Phone #: _____

Email Address: _____

Use This Box If You Want Davison Health Center to **Release** Medical Records.

I authorize Davison Health Center to send my records to the following (Select ONE).

- ☐ Email me my records (Note: This is not a secure email)
- ☐ I will pickup my records in person at the Davison Health Center
- ☐ Mail my records to my mailing address: _____
- ☐ Fax my records to my fax number: _____
- ☐ Send my records to an outside provider:

  Name: _____

  Address: _____

  Fax #: _____ Phone #: _____

Use This Box If You Want Davison Health Center to **Obtain** Medical Records.

I request the following practice/provider send my records to Davison Health Center at Wesleyan University:

Name: _____

Address: _____

Fax #: _____ Phone #: _____

Please release/obtain the following information:

- ☐ Entire Medical Record (may include drug/alcohol, HIV and mental health information)
- ☐ All lab results **OR** Indicate Specific Labs: _____
- ☐ Immunization Records
- ☐ Most Recent Visit Notes and Lab Results
- ☐ Other: _____

I understand that I may revoke this authorization at any time but will not hold the Davison Health Center liable for the release of above stated information prior to revocation. This authorization will expire 90 days from the date of my signature.

Signature: _____ Date: _____

If applicable, email completed release form to **healthforms@wesleyan.edu**