UNIVERSITY OF NORTH CAROLINA WILMINGTON
Student Health Center

RELEASE OF INFORMATION

Name _____ Date _____

Banner ID _____ Date of Birth _____

Phone _____ Last at UNCW _____

Release to _____

Address _____

Fax Number _____

☐ This is a one-time authorization
☐ This authorization will remain in effect for ☐ 1 year or ☐ until ____/____/20___ unless revoked

I give the Student Health Center permission to release the following information to the person or group listed above (initial where applicable)

_____ Immunization & Medical History Form

_____ Immunization Record only

_____ Laboratory Records of _____
(date/test)

_____ Information regarding this illness or incident
Note: You will need to fill out another Release Form for each illness or incident.

_____ Medical Record ☐ complete ☐ selected summary _____
Note: there is a charge of 75 cents per page for medical records

_____ Other _____

Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by federal regulations. I understand that by sending information by facsimile it may be subject to viewing by unauthorized persons.

Signature of patient (or legal representative) _____ Date _____

Witness _____ Date _____

Person releasing the information _____ Date _____

Information released by ☐ Mail ☐ Fax ☐ Copy to patient ☐ Phone SHC rev 05/09