



**Student Health Clinic  
Authorization for Release of Medical Records**

**Student/Patient Information**

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Student ID#: \_\_\_\_\_

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

Lees-McRae Email: \_\_\_\_\_

**Requesting Records From**

**Lees-McRae Student Health Clinic**

191 Main Street West

Banner Elk, NC 28604

Phone: **828-898-8798**

**Release Records To**

Name/Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

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

Email (if secure delivery requested): \_\_\_\_\_

**Records Requested**

**Please select records requested:**

Complete Medical Record

Immunization Records

Physical Exam Forms

Visit Notes/Office Notes

Laboratory Results

Medication Records

Billing Records

Other: \_\_\_\_\_

**Date Range Requested**

From: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ To: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Purpose of Request (Optional)**

- Personal Use
- Transfer of Care
- School/Academic Requirement
- Insurance
- Legal
- Other: \_\_\_\_\_

**Delivery Method**

- Pick Up at Student Health Clinic
- Mail
- Secure Email

**Authorization & Signature**

I authorize **Lees-McRae Student Health Clinic** to release my protected health information as indicated on this form. I understand that:

- This authorization is voluntary.
- I may revoke this authorization at any time by submitting a written request, except where action has already been taken.
- Once disclosed, information may no longer be protected by federal privacy regulations if released to a non-covered entity.
- This authorization expires one (1) year from the date signed unless otherwise specified below.

Alternate Expiration Date (optional): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Signature of Student/Patient or Legal Representative**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship to Patient (if applicable): \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Office Use Only**

Date Request Received: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Processed By: \_\_\_\_\_

Date Completed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Method Sent: \_\_\_\_\_

**Lees-McRae Student Health Clinic**

*Caring for student wellness, health, and success.*