A.H. Ray Student Health Center, Room 244
Student Health Services
601 S. M.L. King Jr. Dr.
Winston-Salem, NC 27110

Phone (336) 750-3301
Fax (336) 750-3303

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the Winston-Salem State University's Student Health Services to release medical information to:

TO: _____
(Name of facility where information is to be sent/ or Your name if information is to be given to you)

ATTN: _____

PHONE: (____)_____ FAX: (____)_____ ADDRESS:
_____
_____
_____

METHOD OF RELEASE:

(CHECK ONE)

_____ **Mail to address given**
_____ **Fax to number given**
_____ **Released to Student**

STUDENT STATUS:
(CHECK ONE)

_____ **Current Student**
_____ **Returning Student**
_____ **Transferring to another school**

RE: _____ **D.O.B** ___/___/___
(Student's Name)

PHONE NUMBER: _____
(Student's Number)

MAIDEN NAME: _____
(If Applicable)

GRADUATION DATE: _____
(If Applicable)

REQUESTED INFORMATION:

_____

*Please provide **date(s) of treatment** below for medical information that you are requesting, except immunization records.
Date(s) of treatment: _____

STUDENT'S SIGNATURE: _____ **DATE:** _____ **WITNESS:**
_____ **DATE:** _____

Completed by: _____ Date/time:_____

Confidentiality Note

The information contained in this facsimile is legally privileged and confidential information intended only for the use of the individual or entity named above. If you are not the intended recipient or the employee or agent responsible for delivering this communication to the intended recipient, you are hereby notified that any reading, distribution or copying of this communication is strictly prohibited. If you have received this facsimile in error, please notify us immediately by telephone at (336-750-3301)