LOYOLA MARYMOUNT UNIVERSITY STUDENT HEALTH SERVICES

One LMU Drive, MS-8455 Los Angeles, California 90045-2659

REQUEST FOR RELEASE OF MEDICAL RECORDS

The purpose of disclosure of medical records is for coordination/ continuity of care.

PATIENT INFORMATION

Patient Name ______________________________ DOB ____________

Phone # ____________________ Email ____________________________

Patient address ____

INFORMATION TO BE RELEASED FROM

I hereby authorize ____
Address ____
Phone number ________________ Fax number ______________________
to release the medical information identified below to ***Loyola Marymount University Student Health Services.***

Loyola Marymount University
Student Health Services
One LMU Drive MS 8455
Los Angeles, CA 90045-2659

Telephone #: 310-338-2881
Fax #: 310-338-4417

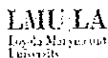
TYPE OF INFORMATION TO BE RELEASED

- ☐ Emergency Room records
- ☐ Hospitalization records/ discharge summary
- ☐ Office/clinic records
- ☐ Psychiatric/mental health records
- ☐ ADHD/ADD records/diagnoses/medications
- ☐ Other records (specify): ____
- ☐ Lab/ Pathology reports
- ☐ Radiology reports
- ☐ Immunization records/ titers
- ☐ Tuberculosis testing/ treatment

Date of service From:____________ To ____________

SIGNATURE

____________	____________	____________
Date	Signature of the patient or legally responsible party	Relationship to the patient if not patient



Authorization valid for 90 days only and may be revoked in writing at any time prior

Rev 5/3/17