LOYOLA MARYMOUNT UNIVERSITY STUDENT HEALTH SERVICES

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

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION

Patient Name _____ DOB: _____

Phone # _____ Email _____

LMU Student ID# _____

I HEREBY AUTHORIZE LOYOLA MARYMOUNT UNIVERSITY STUDENT HEALTH SERVICES TO RELEASE THE MEDICAL INFORMATION IDENTIFIED BELOW TO:

Name of Organization/individual _____
Address _____
Phone number _____ Fax number: _____

PURPOSE OF RELEASE OF MEDICAL RECORDS

☐ Personal use ☐ Coordination of care ☐ Billing/insurance reimbursement ☐ Other:_____

TYPE OF INFORMATION TO BE RELEASED

☐ Office/ clinic records
☐ Lab/pathology reports
☐ Radiology reports
☐ Radiology images
☐ Immunization records/ titers
☐ Tuberculosis testing/ treatments
☐ Billing statements
☐ ADHD/ADD records/diagnoses/medications
☐ Other records (specify): _____

Date(s) of service From:_____ To _____

SIGNATURE

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

Notice: The first copy of each item in your medical records is provided at no cost. You will be charged $10 for each additional copy of the requested medical records. Valid identification is required for medical record release.

LMU|LA Loyola Marymount University

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

Office Use Only: ☐Patient pick up ☐ Fax ☐ Mail ☐ Secure message
Completed by: _____ Completed date: _____

Rev 5/3/17