Dr. Bob Smith Health Center
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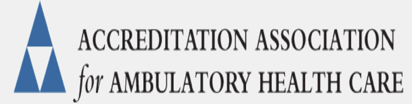

CONSENT TO OBTAIN AND/OR RELEASE MEDICAL RECORDS

Name in Full: (print)____
Last Name First Name MI Maiden (if applicable)

SMU ID#: ________________________________ Patient's Date of Birth____________________________

Patient's Current Address:____

Phone #:________________________________ Are you currently enrolled at SMU? Yes_____ NO_____

Dates of Attendance if not currently enrolled:_______________________to________________________
Month/Year Month/Year

PLEASE OBTAIN MY MEDICAL RECORDS FROM:

Name: __________________________________

Address: ________________________________

City: ________________State:_____Zip______

Phone:_________________Fax_____________

PLEASE RELEASE MY MEDICAL RECORDS TO:

Name: __________________________________

Address: ________________________________

City: _________________State:____Zip______

Phone:_________________Fax_____________

PLEASE CHECK ALL THAT APPLY: Send records via Fax___U.S.Mail____Email____Pick up____

______ Copy of ALL records ($30 charge)
______ Copy of Medical History/Immunization Records
______ Copy of Illness: ______________________________ Date: _________________

______ Copy of Pap/Gyn Records _________________________ Date: ____________

______ Copy of X-ray/Lab: _______________________________ Date: _____________

______ Other (please specify)____

Further, I hereby release ________________, M.D., and Director of Memorial Health Center, their designates, and Southern Methodist University from any and all liability for release of the above-named records. I understand that by signing below I may be waiving the physician/patient privilege. **I understand that I may withdraw this consent in writing at any time.**

Patient's Signature:__________________________ Witness:___________________Date:____________

Records released by:____Date:________________________