Dr. Bob Smith Health Center
Southern Methodist University
PO Box 750195
Dallas, TX 75275-0195

Office: 214-768-2141
Fax: 214-768-2151

SMU Dr. Bob Smith Health Center

AAAHC
ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

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 Dr. Bob Smith 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:_____