STUDENT HEALTH SERVICES
FAYETTEVILLE STATE UNIVERSITY
FAYETTEVILLE, NORTH CAROLINA
Office: (910) 672-1259
Fax: (910) 672-1366

RELEASE OF STUDENT'S MEDICAL RECORD

_____ _____ _____
Name (Please Print) Date of Birth Banner ID

_____ _____
Address City State Zip

I hereby authorize **Fayetteville State University Student Health Services** to release the information requested below from my medical records to:

Name: _____

Address: _____

City/State/Zip: _____

Fax: _____

INFORMATION:

☐**Relating to particular problem(s)** _____

☐**Copy of Immunization Record** _____

☐**Other** _____

_____ _____
Signature of Patient/Student (If patient is a minor, Parent/Guardian signature is required) Date

_____ _____
Signature of Witness Date