



Office of Student Health Services

Phone: 918-495-6341 Fax: 918-495-6274

REQUEST FOR RELEASE OF STUDENT MEDICAL RECORD INFORMATION

I, _____, hereby request Oral Roberts University Student Health Services to release to myself information from my personal Student Health Records.

- _____ All medical records
- _____ Medical Assessment only
- _____ Immunizations Records only
- _____ Other: (specify) _____

I give my permission for this medical information to be used for the following purpose:

If there are any questions regarding this request, the Student Health Office may reach me at phone number:

_____.

I would like to receive my records via the following method:

Mailing Address: _____

Fax Number: _____

Email Address: _____

Please keep in mind that communications via email are not secure. Although it is unlikely, there is a possibility that information included in an email can be intercepted and read by other parties besides the person to whom it is addressed.

Printed Name

Signature of Student

Date of Birth

Witness (must be age 18 or over)

Z Number

Date

NOTE:

There is a \$5.00 processing fee for medical records that are mailed.
You may fax this form back to Student Health Services at 918-495-6274, or by email to studenthealth@oru.edu or send to:
ORU Student Health Services, 7777 S. Lewis Avenue, Tulsa, OK 74171, Attention: Student Health Services