JOHNS HOPKINS UNIVERSITY
Student Health & Wellness Center
3003 N. Charles Street N 200
Baltimore MD 21218-2682
(410-516-8270) / FAX (410-516-4784)

Name: _____

DOB: _____

REQUEST FOR RELEASE OF MEDICAL RECORDS

Please print information.
I hereby give permission to release my medical records from the JHU Student Health & Wellness Center to:

Name: _____

Address: _____

_____

Please check one:
- ☐ *Entire medical record
- ☐Immunization information ($4) *(can be retrieved online via Pyramed Health WebPortal for free)*
- ☐ *Gynecological information only
- ☐ *Information from: _____to_____
- ☐ *Other: _____

Name: _____

Date of Birth: _____ Daytime Phone: _____

School Graduated:

- ☐ School of Arts & Sciences
- ☐ School of Engineering
- ☐ Peabody Conservatory
- ☐ Withdrew/Transfer/Leave of Absence

Level:

- ☐ Undergraduate
- ☐ Graduate
- ☐ Post-Doc
- ☐ Peabody

Last year attended: _____

By signing the authorization, I understand that medical records released may contain information related to HIV status, AIDS, sexually transmitted disease, mental health, drug and alcohol abuse, etc. Medical information contained in records at the Johns Hopkins university Student health & Wellness Center does not contain psychotherapy notes. A separate authorization from the Johns Hopkins University Counseling Center is required to release psychotherapy notes. This authorization expires one year from the date it is signed.

_____ _____
Signature Date

***Please allow 5-7 working days for your records to be copied. Copying fees are set by the State of Maryland and currently are $0.76/page plus the cost of shipping, unless you request they be sent directly to your healthcare provider or medical facility.**

Fax Charges: $3.00 1st page; $2.00 each additional page.

FOR OFFICE USE ONLY:

Sent Date:_____

Circle one: faxed/ mailed/given to requestor

Sender's Initials:_____

Revised: 6/14