

UNIVERSITY OF THE  
**PACIFIC**

Request for Release of Records

|                            |                  |
|----------------------------|------------------|
| Patient Name:              | Date of Birth:   |
|                            |                  |
| Patient # (if applicable): | Date of Request: |
|                            |                  |

I, \_\_\_\_\_ request and authorize the University to duplicate and release my records.

I wish my records to be sent directly to a third party.

Mailing Address:

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|  |
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|  |
|  |

I wish my records to be emailed (please be advised that communications via email may not be secure)

|                |  |
|----------------|--|
| Email Address: |  |
|----------------|--|

Please note: A fee may be charged for repeat requests.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authority of Personal Representative

Internal Use Only

|                         |  |
|-------------------------|--|
| Date Request Completed: |  |
| Component Liaison Name: |  |