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:

☐ 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:	