University of Rochester University Health Service www.rochester.edu/uhs

Completed forms should be returned Attn: Medical Records

Email- HHF@uhs.rochester.edu

Fax- 585-756-0263

Mail- University Health Service 738 Library Rd, Box 270617, Rochester NY 14627

Authorization for Release of Medical Information

For the release of medical records from the University of Rochester Medical Center (URMC) / Strong Memorial Hospital (SMH), call 585-275-2605

Patient's name:		Date of Birth:	
•		Patient's phone #: (, ,
		Student ID:	
Date Needed: _		Forward Records to:	(Provider/MD/NP Name
This Authorization	on allows University	y Health Service to: (check one or both)	
0	SEND copies of yo	our record to the provider/person/facility below	
0	REQUEST copies	of your record from the provider/person facility belo	ow
0	Exchange of Verb	al Communication with the provider/person below	
Name of Provide	r/Person/ facility		
Address			
City/State/Zip Co	- da		
	•	- · ·	_
Phone# (include	area code)	Fax#	
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