CHAPMAN UNIVERSITY

STUDENT HEALTH CENTER

ONE UNIVERSITY DR.

ORANGE, CA 92886

Office (714) 997-6851

FAX (714) 744-7077

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE MY RECORDS

TO: , CHAPMAN UNIVERSITY

OR:

The complete history records in your possession concerning my illness and/or treatment during/for: to:

Name: Date of Birth:

Address:

City: State: Zip:

Signature: _____ Date:

Witness: _____ Date: