SHAW UNIVERSITY 1865 | Counseling Center

NOTICE OF DISCHARGE FOLLOW-UP

Patient Name ____________ ID # ____________ DOB ____________

Address ____________ City ____________ State ____________ Zip Code ____________

Phone Number ____________ Email ____________

I request and authorize the specified medical facility:

____

to release the Protected Health Information of the patient named above to:

- ☐ **PATIENT:**
- ☐ Mail to Address Above
- ☐ Pick-up
- ☐ E-mail: ____________

- ☐ **SHAW:**
- ☐ Shaw Campus Health Center
- ☐ Shaw Counseling Center

Information to be Released

- ☐ Billing Records
- ☐ Counseling and Psychological Records
- ☐ Entire Record
- ☐ Immunization Records
- ☐ Prescription History
- ☐ X-Ray Films

Purpose of the Release

- ☐ Attorney/Legal
- ☐ Continued Patient Care
- ☐ Insurance
- ☐ Parental/Guardian Communication
- ☐ Personal Use
- ☐ Other: ____________

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