SHAW UNIVERSITY 1865 | Counseling Center

Shaw University Counseling Center
NOTICE OF DISCHARGE FOLLOW-UP

Patient Name: _____ ID #: _____DOB: _____

Address: _____ City: _____
State: ____ Zip Code: _____

Phone: (___) _____Email:_____

I request and authorize the specified medical facility:_____

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

☐ Shaw Campus Health Center

☐ Shaw Counseling Center

☐ Patient:

☐ Mail to Address above

☐ Pick-up

☐ E-mail: _____

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:
_____