



HEALTH SERVICES  
**BELMONT**  
UNIVERSITY

Fax # (615) 460-6131

**RELEASE of INFORMATION**

\_\_\_\_\_ **AUTHORIZES**  
Name of Patient

**BELMONT UNIVERSITY HEALTH SERVICES TO RELEASE HIS/HER MEDICAL RECORD(S)**

**TO** \_\_\_\_\_  
Name of Person or Organization

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date