UNIVERSITY OF BRIDGEPORT

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH RECORDS

Name (Last): ______________________________

First: ______________________________

Date of Birth (MM/DD/YYYY): ______________________________

Student ID #: ______________________________

Phone Number: ______________________________

Mailing Address: ______________________________

City: ______________ State: ______________ Zip code: ______________

Email: ______________________________

Year of Graduation/Left University of Bridgeport: ______________________________

Dates of Service Requested:

From (MM/DD/YYYY) ______________ to (MM/DD/YYYY) ______________

I understand that my request for a copy of my health records: 1) will be processed within 7-14 business days; 2) will be mailed to the address provided on this form; 3) cannot be emailed or faxed.

______________________________ ______________________________

Printed name/signature Date (MM/DD/YYYY)