MARIAN UNIVERSITY
Indianapolis ®

Consent for Release of Medical/Immunization Records

Marian University Student Health Center

Thank you for contacting the Marian University Student Health Center. It may take 24 hours to forward your requested information. In order to respond to your request, the following information is required:

Student Name:_____ Maiden Name:_____

Date of Birth:_____

Last 4 digits of social security number:_____

Date of enrollment:_____ Date of graduation_____

Medical information requested:_____

_____

_____

_____

Recipient of requested information:

Name:_____

Title:_____

Phone number:_____ Fax number:_____

Address:_____

E-mail address:_____

When completing this form and sending it to the Marian University Student Health Center, your actions indicate you give permission to the above requested information to be released to the named person or institution. You may email the form to: bclarke@marian.edu,
fax it to 317-955-6133, or mail it to Marian University Student Health Center, 3200 Cold Spring Road, Indianapolis, IN 46222