



HEALTH SERVICE MEDICAL RECORDS REQUEST

Date _____ Campus _____

Students Full Name _____ DOB _____ ID Number _____

Information request- Please be specific

Reason for medical records

Please note medical records requests may take up to 48 hours to process.

Printed Name of Requestor _____

Signature of Requestor _____

Contact phone number should we need to contact you with any questions _____

FOR WFISD HEALTH SERVICE USE ONLY

Date request was received by Health Service _____

Records prepared by: _____ Date Records were supplied _____

Records supplied/delivered by: _____

Signature of requestor on delivery _____ Date _____