



## Student Health Center

3<sup>RD</sup> Floor Student Center

Phone 412-392-3800 • Fax 412-392-3801

### Medical Record Request Form

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Student Phone Number: \_\_\_\_\_

Student Email Address: \_\_\_\_\_

Year Entered PPU: \_\_\_\_\_ YEAR Exited PPU: \_\_\_\_\_

This may include but is not limited to documented information such as immunization records, date/time of visits, medical history and evaluation, assessment details, plan of treatment, doctor appointments, transport to other medical facilities.

For the following purposes:

- Continuity of care
- Coordination of care
- Proof of immunization
- Other (please specify): \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_