REQUEST FOR INFORMATION FROM
UNIVERSITY HOSPITAL EMPLOYEE HEALTH

I request a copy of my _____

This information has been provided to me on _____
(DATE)

_____
(Print Name)

_____
(Signature)

_____
(Maiden Name If Applicable)

_____
(Social Security #)

_____
(D.O.B.)

_____
(TODAY'S DATE)

Complete This Section If You Are Authorizing Persons Other Than Self To Pick Up Documentation

Person Picking Up Records Must Have Photo Identification

I _____ **give authorization for my records to released to**

_____
Name of Person to Pick Up

_____
Please Sign Here

_____
(Date)