

**UNIVERSITY OF THE SCIENCES IN PHILADELPHIA
STUDENT HEALTH OFFICE
600 SOUTH 43rd ST.
PHILADELPHIA, PA 19104**

PHONE: 215 - 596-8980

FAX: 215 - 596-7621

Signed permission for release or transmittal of information.

Name: _____

Address: _____

Birthdate: _____

I give permission for the USP Student Health Office to obtain or release pertinent clinical information regarding the above named person from/to

DATE

Signature of patient or guardian

Signature of witness

Information requested: _____
