



UNIVERSITY of PENNSYLVANIA
Student Health Service
Medical Records Department



3535 Market Street, Suite 100 Philadelphia PA 19104
 Phone: 215-746-3535 Fax: 215-746-0847 E-mail: shsmr@pobox.upenn.edu

PATIENT REQUEST FOR COPY OF MEDICAL RECORDS

Patient Name _____ Birthdate _____

Penn Student Identification Number _____

Current Student? Yes No (If NO, my Graduation Date was ___/___/___)

Request Duplication Request Viewing Access

The duplication charges are as follows: Immunization/physical only: \$5.00,
 Entire chart or selected portions (includes immunizations) \$20.00.

Checks should be made payable to The Trustees of the University of Pennsylvania. Payment is made at time of request. There is no fee for current students picking up immunization records in person.

HEALTH HISTORY INFORMATION WILL ONLY BE RELEASED TO THE STUDENT

I hereby request from the University of Pennsylvania Student Health Service a copy of my medical chart.

Comments/special requests:

Please mail the above information to me at _____

Name _____

Address _____

(If you wish to receive your chart via FedEx or UPS, you must provide a pre-paid FedEx or UPS envelope.)

I will pick up my chart from Student Health Service Medical Records.

I request to receive my medical records in electronic format.

(Fax #: _____

E-mail address: _____

Contact phone #: _____)

Please note that the Student Health Service will not duplicate any material that was not originated in the Student Health Center.

Patient signature: _____ Date: ___/___/___

A response to your request will be mailed to the above address within thirty (30) day of receipt of request.

For Medical Records use only

Date request received: _____ *Verification of patient's identity:* _____

Request is **Approved:** **Date copy mailed:** _____

Denied: **Date denial response** ___/___/___