Request for Access to Student Immunization Records

Converse University Wellness Center
Health Services

580 E. Main St. Spartanburg, SC 29302 ◆ Phone: (864) 596-9258 ◆ Fax: (864) 596-9729

This form is used to request a copy of your immunization records. The Wellness Center maintains student health information for ten years per South Carolina law. Please allow up to 3 business days to for the Wellness Center to provide your records.

We are required to receive your permission before releasing these records. As a student, you are entitled to a copy of your records; however, the records are the property of the Wellness Center and guidelines are in place to protect you. This form must be completed, signed, and returned to us before the release of records can occur. If you would like your records to be sent to multiple providers or institutions, separate requests are required.

Please complete all sections of this form. Please note that incomplete or inaccurately completed forms will not be honored.

Name: _____

Social security number: _____ Date of birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____

Please list your dates of attendance at Converse: _____ /_____ to _____ /_____
Month *Year* *Month* *Year*

I hereby authorize the Converse U Wellness Center to release my immunization record to:

Individual, provider, or institution: _____

Address: _____

Phone number: _____ Fax number: _____

Method of Delivery: ❑Pick-up ❑Mail ❑Fax

Per Wellness Center policy, records will only be faxed to another medical provider or college. All other requests will be mailed or you can pick up in person.

I understand that any incomplete form returned to Converse University Wellness Center will be returned to me for completion and my access request will not be implemented until all the information is received complete and processed.
I also acknowledge that Converse University staff has the right to request identification (e.g., a driver's license) in order to verify the identity of any individual requesting records. Individuals who are unable to present this form and identification in person may be asked to have this form notarized in order to protect the confidentiality of all former and current students' records.

Please forward this request to:
Converse University Wellness Center
580 East Main Street
Spartanburg, SC 29302

I have read and understand the above information:

Signature: _____ Date: _____

If recipient of services is unable to give consent because of physical condition or age, complete the following:

Patient is a minor of _____ years of age or is unable to give consent, because: _____

_____

Signature of Parent/Guardian/POA: _____

Relationship: _____

Signature of Personal Representative: _____

Relationship: _____