Wabash.

RELEASE OF MEDICAL INFORMATION

Date: _____

To: _____

Address: _____

I hereby request that my medical records be released to:

Dr. Scott K. Douglas and/or Dr. John R. Roberts	Sports Medicine Department
Wabash College Student Health Center	Allen Athletics Center
301 W. Wabash Avenue	Fax: 765-361-6146
Crawfordsville, IN 47933	Phone: 765-361-6235

_____ _____

Name Date of Birth

Additional Notes: