LAKEVIEW
COLLEGE OF NURSING

Health Records Release Form

A fee of $5.00 is required prior to issuance. Please allow up to 1 week to process request after authorization form has been received.

Name: _____
Last First Middle

Phone #: (_____)_____ E-mail Address: _____

I request that a copy of all my health and immunization records currently on file at Lakeview College of Nursing be sent to the recipient below:

FAX to: Attn: _____ (Name/Department)

Fax #: (_____)_____

-OR-

MAIL to: Attn: _____ (Name/Department)

Address: _____ (Street Address)

_____ (City/State/Zip)

My signature below authorizes release of my health records to be faxed or mailed as requested above.

Signature: _____ Date: _____

Type of payment (please circle one): Cash Check VISA MasterCard Discover

Number (if using credit card) _____--_____--_____--_____

Expiration Date: _____ V-Code: _____ (3 digit code on the back of the card)

FAX, E-MAIL/MAIL, OR DELIVER FORM TO:

LAKEVIEW COLLEGE OF NURSING
ATTN: REGISTRAR'S OFFICE
903 N. LOGAN AVENUE
DANVILLE, IL 61832
FAX: (217) 709-0953
E-MAIL: AGRANT@LAKEVIEWCOL.EDU