NOTRE DAME
OF MARYLAND
UNIVERSITY

SCHOOL OF PHARMACY

Patient Medical Records Release Consent Form

As part of the Pharmacy educational program, a pharmacy student at Notre Dame University of Maryland will be working with me for the length of a year. He/She will need my medical records for the purpose of the pharmacy educational learning process. Accordingly, I give my consent for my medical /prescription records to be released to (print student name)_____.

Thank you

Date _____

Name (Print)_____

Signature _____

Telephone Number_____