STUDENT HEALTH SERVICES
FLORIDA A&M UNIVERSITY
TALLAHASSEE, FLORIDA 32307
PHONE: 850-599-3777
FAX NUMBER: 850-412-5643

MEDICAL RECORD RELEASE AUTHORIZATION

Federal law states that we cannot share your health information without your permission except in certain situations. If you sign this form, you are giving us permission to share the information you indicated below. If you decide later that you <u>do not</u> want us to share your information any more, you may revoke this authorization at any time in writing.

I,_____, DOB_____, ID#_____
(Date of Birth)

Request/authorize health information to be released to:

Florida A&M University, Student Health Services
116 Foote-Hilyer Administration Center
Tallahassee, FL 32307

Phone: (850) 599-3777

Fax: (850) 412-5643

Medical records release from:

_____
_____
_____

Phone:_____

Fax:_____

☐ Entire Medical Record From_____ To_____

☐ Problem List ☐ Medication Profile ☐ Immunizations

☐ History and Physical ___Most Recent ___All ___Other:_____

☐ Diagnostic Test Reports ☐ Laboratory Results ___All From_____ To_____

☐ Pap Smear

☐ Referral Consultation:_____

☐ Other_____

By my initials I specifically consent to release information relating to:
___STD ___HIV/AIDS ___TB ___Drug/Alcohol ____ Mental Health/Psychiatric

For the purpose of:_____

_____ _____
Patient/Legal Representative Signature **Date**

_____ _____
Print Name **Relationship**

_____ _____
Witness **Date**

*I understand that this authorization is valid for **90 days** after the date of my signature. I also understand that this authorization can be revoked, except to the extent that action had already been taken to comply with it. Information documented in my record after my signature will not be released. If you are picking up these records and have not picked them up by 10 days after the dated request, they will be mailed to the address below.* **<u>I am also responsible for any charges for this service.</u>**

Name:_____ DOB:_____

Address:_____ Phone:_____

Signature:_____ Date: _____