



STUDENT'S SIGNATURE **MUST BE NOTARIZED** FOR INFORMATION TO BE RELEASED.

Authorization for Release of Medical Information

I authorize

Name of sending person, agency or institution

Address

City State Zip

Phone Fax

to release to

Name of receiving person, agency or institution

Address

City State Zip

Phone Fax

The following information: (information to be released must be clearly specified):

in regard to _____ - _____ - _____ / ____ / ____
Name of Student Student # Social security number Date of birth

for the purpose of (clearly specify) _____

I understand that I may revoke this consent at any time except to the extent that action has been taken based on this authorization.

Signature of student or responsible person

Date

SWORN to before me and subscribed in my presence this ____ day of _____, 20____

Notary Public
My Commission Expires: _____ [Seal]