



**Authorization for Release of Medical Information**

I authorize

\_\_\_\_\_  
Name of sending person, agency or institution

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

to release to

\_\_\_\_\_  
Name of receiving person, agency or institution

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

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

\_\_\_\_\_  
\_\_\_\_\_

in regard to \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Name of Student Colleague # 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

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date