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 do not 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:

____

____

____

Phone:______________________

Fax:_________________________

Medical records release from:

____Florida A&M University, Student Health Services__

____1735 Althea Gibson Way, Suite 104_____________

____Tallahassee, FL 3230________________________

Phone: (850) 599-3777

Fax: (850) 412-5643

☐ 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.* **I am also responsible for any charges for this service.**

Name:____ DOB:__________________________________

Address:_______________________________________ Phone:_________________________________

Signature:_____________________________________ Date: _________________________________