

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:

Medical records release from:

_____ Florida A&M University, Student Health Services _____

_____ 1735 Althea Gibson Way, Suite 104 _____

_____ Tallahassee, FL 3230 _____

Phone: (850) 599-3777

Phone: _____

Fax: (850) 412-5643

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

Name: _____

DOB: _____

Address: _____

Phone: _____

Signature: _____

Date: _____