



FLORIDA ATLANTIC UNIVERSITY

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ hereby authorize

Name: _____

Address: _____

FAX No.: _____

to release to: **Florida Atlantic University
Student Health Services
777 Glades Road
PO Box 3091
Boca Raton, FL 33431-1091**

the following information from my medical records:

- | | |
|--|---|
| <input type="checkbox"/> Entire medical record | <input type="checkbox"/> Progress notes |
| <input type="checkbox"/> Immunization record | <input type="checkbox"/> History and Physical |
| <input type="checkbox"/> Laboratory test | <input type="checkbox"/> Problem List |
| <input type="checkbox"/> Other (specify) _____ | |

The purpose or need for the information is:

- Continuity of care/Another Physician
- School requirements for registration
- Other (specify) _____

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 the action has already been taken to comply with it. Information documented in my record after the date of my signature will not be released.

I understand that the information released cannot be redisclosed by the person or institution named above unless I specifically authorize such a release in writing.

Date

Signature of patient or Legal Representative

Student ID/Z Number

Legal Representative's Relationship to Patient

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