University of North Florida

STUDENT HEALTH SERVICES/MEDICAL COMPLIANCE

Phone: (904) 620-2175 Fax: (904) 620-2901

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Student/Patient Name: (print) _____

Student ID # N_____ Date of Birth: _____ Phone #: (____)_____

CONSENT FOR RELEASE OF MEDICAL INFORMATION:

Florida law requires that information contained in medical records be held in strict confidence and not be released without your written authorization. This Authorization for Release of Medical Records is a one-time request. Any further requests will necessitate the completion of a new form. You have right to receive a copy of all parts of this authorization upon your request. **YOU MUST PROVIDE A PHOTO I.D. TO OBTAIN RECORDS.**

I, _____ authorize UNF Medical Compliance to release:

Name of Student/Patient or Legal Representative

Please initial by (a, b, c, d) any or all that apply:

____a. The general immunization records

____b. STD records

____c. TB records

____d. HIV / AIDS records

Please release to: ____ ME and/or a ____ PHYSICIAN/INSTITUTION

via (please circle one) IN PERSON / EMAIL / FAX / MAIL

Name of Contact/Facility: _____

Address or Email: _____

Fax #: _____

For the purpose of: _____

Date:_____ _____

Signature of Student / Patient or Legal Guardian (picture id required)

Witness: _____ _____

Legal Representative's Relationship to Patient

Rev. 1-29