**University of North Florida**

**STUDENT HEALTH SERVICES/MEDICAL COMPLIANCE**

Phone: (904) 620-2175 Fax: (904) 620-2901 Email: medical\_compliance@unf.edu

# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

**Student/Patient Name:** Click or tap here to enter text.

**Student ID # N**Click or tap here to enter text.

**Date of Birth:** Click or tap here to enter text. **Phone #:** Click or tap here to enter text.

## 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,** Click or tap here to enter text.**, 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**

**e. Other:** Click or tap here to enter text.

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

**via (please check one)  IN PERSON /  EMAIL /  FAX /  MAIL**

**Name of Contact/Facility:** Click or tap here to enter text.

**Address or Email:** Click or tap here to enter text.

**Fax #:** Click or tap here to enter text.

**For the purpose of:** Click or tap here to enter text.

**Date:** Click or tap here to enter text.Click or tap here to enter text.

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

**Witness:** Click or tap here to enter text.Click or tap here to enter text.

**Legal Representative’s Relationship to Patient**