**UNIVERSITY OF NORTH FLORIDA**

**STUDENT HEALTH SERVICES / MEDICAL COMPLIANCE**

# Authorization for Release of Medical Information

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

**Print Name**

**Address:**Click or tap here to enter text. **City/State/Zip:** Click or tap here to enter text.

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

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**The above listed patient authorizes the following facility to make record disclosure:**

**Facility Name:** Click or tap here to enter text. **Facility Phone:** Click or tap here to enter text.

**Address:** Click or tap here to enter text. **Facility Fax:** Click or tap here to enter text.

**City, State, Zip:** Click or tap here to enter text.

**To Release by mail or fax to:**

**University of North Florida**

**Student Health Services / Medical Compliance**

**1 UNF Drive**

**Jacksonville, Florida 32224-2645**

**Fax # (904) 620-2901 Phone # (904) 620-2175**

**The purpose or need for the information is:**

**Immunization required at University of North Florida**

**I understand that this authorization is valid for one year after the date of my signature. I also understand that this authorization can be revoked, except to the extent that 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 re-disclosed by the University of North Florida Medical Compliance office unless I specifically authorize such release in writing.**

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| **Date** | **Signature of Student or Legal Representative** |

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|  |
| **Legal Representative’s Relationship to Student** |

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| --- | --- |
|  |  |
| **Date** | **Witness** |

|  |  |
| --- | --- |
|  |  |
|  | **Checked ID** |

**(Rev. 11/12)**