AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby give consent to:

_____ _____
(Name of Institution/Person) (Phone Number)

_____ _____
(Street Address) (Fax Number)

_____ _____ _____
(City) (State) (Zip Code)

where I received care from_____ to _____.

Please release the following information:

_____ Entire Medical Record _____ TB Test Results

_____ Chest X-Ray _____ Health Form

_____ Immunization _____ Other (Specify)

_____

Lincoln University Student Health Services, 822 Lee Dr., Thompkins Health Center, Jefferson City, MO 65102-0029

FAX (573) 681-5877

_____ _____

(Patient Signature) (Social Security Number)

_____ _____

(Print Name) (Date of Birth)

_____ _____

(Witness Signature) (Today's Date)