Southern University
Student Health Center
Phone 225-771-4770 Fax 225-771-6225
Authorization to Release Medical Information Request Form

Release Authorized By: _____
Name

_____
Address

_____
City State Zip

_____
Phone Number

_____ _____
Social Security Number Date of Birth

I hereby authorize release of information in my health records from the following institution or individual: _____
_____
_____

To the following institution: **Southern University Student Health Center**
Po Box 10174
Baton Rouge, La 70813
☐ **Please fax documentation to the number above**
☐ **Please mail documentation to the address above**

Purpose: I authorize the release of my health information for the following specific purpose:
☐ Further medical care ☐ Personal ☐ Legal investigation or action ☐ Changing Physicians
☐ Research related treatment ☐ Creating health information for disclosure to a third party
☐ Other_____

Information to be disclosed:
☐ Entire medical record ☐ Medical history, examination, reports ☐ Laboratory reports
☐ Diagnostic reports ☐ Prescriptions ☐ Immunizations ☐ Treatment/Tests ☐ Hospital records

I understand that this authorization will remain in effect for one (1) year from the date of this authorization form.

I understand the release of information may be revoked in writing at any time by providing a written notice of revocation to the Student Health Center at the address listed above.

The revocation would be effective immediately upon my Health Care providers' receipt of my written notice.

_____ _____
Signature of Patient **Date of Authorization**

_____
Witness