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