Office of Health Services, 74 King Street, St. Augustine, FL 32084
Phone: (904) 819-8579, Fax: (904) 824-1183 healthservices@flagler.edu

FORMER FLAGLER STUDENTS ONLY:

Authorization for Release of Medical Information

CONSENT FOR RELEASE OF MEDICAL INFORMATION:

Florida Law requires that information in your medical records be held in strict confidence and not be released without your written authorization. This authorization will remain in effect until you request in writing that your authorization be withdrawn, which you may do at any time. You have a right to receive a copy of all parts of this authorization upon your request.

It is implied that by submitting this form you are giving your consent for release of medical information.

I, ____, (name of student) authorize Flagler College to release my:

Check One or Both: ______ **general immunization records** ______ **ALL Medical Information**

Student Name: ____

Student Date of Birth: ____________________ **Student Social Security # (last 4 digits only)** _______________

Student Phone Number: ____

Student Email address: ____

RELEASE RECORDS TO: (select one) **Student** ______ **College/Univ.** _______ **Doctor**______ **Other** ______

Name of Institution or Group: ____

Institution or Group Contact name: ____

EMAIL of institution: (NO FAXES) ____