



Office of Student Services, 74 King Street, St. Augustine, FL 32084
Phone: (904) 819-6238, Fax: (904) 810-2253. studentservices@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 This authorization will remain in effect until you request in writing that your authorization be withdrawn, which you may do at any time.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) _____