Southern University
Student Health Center

Phone 225-771-4770 Fax 225-771-6225

Medical Release of 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
225-771-6225 fax

☐ **Please fax documentation to the number above**

☐ **Please mail documentation to the address above**

Information Requested:

_____

_____

I understand the release of information may be revoked in writing at any time

_____ _____
Signature of Patient **Date**

_____
Witness