THE UNIVERSITY of NEW ORLEANS

Office of Student Affairs

RELEASE OF MEDICAL INFORMATION CONSENT

(Complete Name/Address/Phone Number of Facility Releasing Information)

I hereby authorize ____

Address: ____

Phone: ______________________________Fax:__________________________

(Complete Name/Address/Phone Number of Facility Receiving Information)

To disclose to____

Address: ____

Phone: ______________________________Fax:__________________________

I consent to the following documents of medical record to be disclosed to the above facility /person. Check all that apply:

_____Medical Records _____Test/Lab Reports _____X-ray Report _____Immunizations

Other: ____

I understand that I may revoke this consent at any time, except to the extent that the action has already been taken. In Reliance hereon and if not sooner in writing, this consent will expire in 90 days from the dated signed .

______________________	______________________
(Print Name)	(Signature)
______________________	______________________
(Date of Birth)	(Student ID #)
______________________	______________________
(Date Signed)	(Witness Signature)

________I understand medical records/information may be transmitted via fax or email. I release University of New Orleans employees from any legal liability, which may arise from the disclosure of this information.

FOR OFFICE USE ONLY

FAXED___ EMAILED___ MAILED___ PICKED UP___ Date Completed ______/______/______by______

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