



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize release of information from	m the Medical Record	f:	
Patient Name:		Date of Birth:	
(Please Print)			
Social Security last 4 #:	CSU ID#:909	Daytime Phone #:	
Release Information To:	<u>Request</u>	Information From:	
Please Release the following: (please check Lab Reports Immunizations Other Diagnostic Reports (specify tests Other (specify)	s and dates)		
Purpose of need for disclosure: Personal Use Continued Health Care with other Prov Other (specify)	I will ider Please Fax c		
consent of the patient is prohibited. I further $\boldsymbol{\iota}$	inderstand that unless oth sed on my consent, I may	ted above. Any other use of this information without the written terwise limited by state or federal regulation, and except to the withdraw this consent in writing at any time. This consent will	
Signature of Patient or Legal Representative	Date		
Relationship to Patient	Witness	Date	
COMPLETE ONLY IF INFORMATION IS TO BE	RELEASED DIRECTLY TO	O PATIENT:	
		hat only a physician can interpret. I understand and have been advised rd to prevent my misunderstanding of the information contained in these	
I will not hold Columbus State University Student H consulting my physician for the correct interpretation		isinterpretation of the information in my medical record as a result of not	
Signature of Patient or Legal Representative	Date		
Relationship to Patient	Witness	Date	
FOR OFFICE USE ONLY: Date request completed:	#copies copied:	Initials:	