

**STEPHEN F. AUSTIN STATE UNIVERSITY
HEALTH SERVICES**

MEDICAL RELEASE FORM

(Please Print or Type)

Date: _____

Student: _____ ID # _____ DOB: _____

Address: _____
Street City State Zip Code

Phone: _____ Fax: _____

I, _____, hereby authorize _____
Physician/Clinic to Send Medical Records

Phone: _____ Fax: _____

To release (information listed below) to: Stephen F. Austin State University Health Services
PO Box 13058, SFA Station
Nacogdoches, TX 75962-3058
Phone: (936) 468-4008
Fax: (936) 468-1316

The information to be released is limited to the following: (Please initial all items for which release is approved.)

- _____ Copy of Entire Medical Record
- _____ History Form
- _____ Treatment Notes
- _____ Other _____

The following information **may not** be released _____

Your signature below indicates that you have read the above information and that you agree to the release of information as described above. I, the undersigned do hereby authorize Stephen F. Austin State University release/request information from the medical record. I understand that I may revoke this authorization at any time. This authorization will expire on _____.

Signature of Patient

Patient Name (Please Print)

Signature of Witness

Date

The information in this fax is confidential and privileged to the intended listed above. Should this transmission be received in error you are hereby notified that any disclosure or distribution is strictly prohibited. Please return to sender.