STEPHEN F. AUSTIN STATE UNIVERSITY HEALTH CLINIC
FROM SFASU Medical Release Form

SFA Health Clinic please send Medical Records on:

(Please Print or Type) Date: _____

Student: _____ ID # _____ DOB: _____

Phone(s): _____

I, _____, hereby authorize

Stephen F. Austin State University Health Clinic
PO Box 13058, SFA Station
Nacogdoches, TX 75962-3058
Phone: (936) 468-4008
Fax: (936) 468-1316

To release (information listed below) to: _____

Address:_____

Phone: _____ Fax: _____

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's 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 nay disclosure or distribution is strictly prohibited. Please return to sender.