Franklin Pierce University

**Health Services**

Tel (603 899-4130 * Fax (603) 899-1050 * healthservices@franklinpierce.edu

# AUTHORIZATION FOR RELEASE OF INFORMATION

**(Please PRINT)**

Student Name: _____ DOB: _____/_____/_____
**Last First Middle Mo. Day Yr.**

Student ID# _____ Years of Attendance _____ Phone/Cell _____

Home Address: _____
**Street City State Zip**

**(CHECK APPROPRIATE BOXES AND COMPLETE APPLICABLE INFORMATION BELOW)**

☐ I authorize and request the release of my health information **FROM** Franklin Pierce University/Health Services **TO:**

Name: _____

Address: _____

Phone #: _____ Fax #: _____

☐ I authorize and request the release of my health information **TO** Franklin Pierce University/Health Services **FROM:**

Name: _____

Address: _____

Phone #: _____ Fax #: _____

☐ Provide **me** with a copy of my health information. ☐ I will pick up this information ☐ Mail to me ☐ Email to me

Name: _____

Address: _____

Phone #: _____ Email address: _____

Release the following health information:

☐ **Immunizations** ☐ **Physical** ☐ **Other:** _____

This information has been disclosed to you from records protected by State and Federal Laws. This authorization is valid for 90 days and may be revoked in writing prior to the expiration date. Additional authorization for disclosure beyond recipient, is required.

_____ _____

**Student Signature** **Date**