AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the University of Miami Student Health Service to release and discuss the following information: (Check One)

_____ All of the contents of my student health record, including previous diagnosis, treatments and physical limitations
( ) including mental health, psychiatric, or psychological information
( ) excluding mental health, psychiatric, or psychological information
( ) not applicable

( ) including HIV test results
( ) excluding HIV test results
( ) not applicable

____ Only information pertaining to the condition(s) for which I was seen at the Student Health Service, at any time, including diagnosis, treatment, and physical limitations, Condition and Date(s) of Visit:
_____
_____

____ Only my physical limitations as recommended by a Student Health Service practitioner during my last visit to the Student Health Service.
(Date of last visit: _____)

This information is to be released to: _____
_____

Date, event or condition upon which this consent expires: _____

NOTE: If no specification is entered, the authorization will be in effect for 60 days from the date of the signature.

I understand that if there is a charge for this service, it will be my responsibility. I hereby release and discharge the University of Miami Student Health Service, its employees and officers from any legal responsibility or liability for the release of my medical records to the person(s) and/or entity(ies) indicated above.

Patient Name _____ Date of Birth _____

Address _____ Student #_____

Patients Signature _____ Date _____

Parents Signature _____ Date _____
(If student is under 18 years of age)

Witness _____ Date _____