LYNN UNIVERSITY HEALTH CENTER

Authorization for Release of Medical Information

I, _____ hereby authorize Lynn University Health Center to release my medical information to:

Name: _____
Address: _____
_____
Fax # _____

The following information from my medical records:
____ Immunization record ____ most recent physical exam
____ Other _____
_____

For the purpose of: ___ school requirements for registration
___ Other _____

Please: _____ mail _____Fax _____ Pick-up

I understand that the information released cannot be disclosed by the person or institution named above unless I specifically authorize such a release in writing.

Name: _____
Last year attended Lynn:_____ Student I.D. # _____
Telephone: _____ Date of Birth: ____/____/_____

Signature of patient: _____ Date: ___/___/___

Lynn University-Health Center
3601 North Military Trail
Boca Raton, Florida 33431
Telephone: 561-237-7231 Fax: 561-237-7116
www.lynn.edu/healthcenter

***Please Note: It may take 7-10 business days to locate your records.**
****Lynn University Health Center only holds records for 7 years.**

For Health Center Staff Only

ID checked	Date Picked up
Staff initials	Date mailed
	Date faxed