# LYNN UNIVERSITY HEALTH CENTER

## Authorization For Release Of Medical Information

I, _____ hereby authorize

Name: _____
Address: _____
_____
Fax # _____

To release to: Lynn University
Health Center
3601 North Military Trail
Boca Raton, Florida 33431

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

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

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.

Date: _____
Signature of patient: _____
Student ID# _____

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