EMBRY-RIDDLE
Aeronautical University

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize: ERAU Health Services - 600 S. Clyde Morris Blvd. Bldg 500
Daytona Beach, FL 32114-3900 (T) 386-226-7917 (F) 386-226-6082

To release to: _____
Name of sending person, agency or institution

_____
Address

_____
City State Zip Code

_____ _____
Phone Fax

The following information, please check;

- ○ Immunizations
- ○ Medical History
- ○ Labs (specify date/s)_____
- ○ Radiology (specify date/s)_____
- ○ Gynecology (specify date/s)_____
- ○ Other_____

Regarding _____ _____ ___/___/_____
Student Name Student ID Date of Birth

I understand that I may revoke this consent at any time except to the extent that action has been taken based on this authorization. **RELEASE FORM MUST BE NOTARIZED IF NOT SIGNED IN PERSON.**

→ _____ _____
Signature of student or responsible person **Date**

Witnessed by: _____ _____
ERAU Employee **Date**

NOTARIZATION
SWORN to before me and subscribed in my presence this_____day of_____, 20____

_____ My commission Expires:_____[Seal)
Notary Public