

EMBRY-RIDDLE

Aeronautical University

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize: ERAU Health Services - 600 S. Clyde Morris Blvd. Bldg 20
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____

Notary Public My commission Expires: _____ [Seal]