EMBRY-RIDDLE
Aeronautical University

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I AUTHORIZE: Embry-Riddle Aeronautical University Health Services

1 Aerospace BLVD. Bldg. 500, Daytona Beach, FL 32114

Phone: 386-226-7917 Fax:386-226-6082

To Release To: _____

Name of Person, Agency, or Institution

_____

Address

_____ _____

Phone Number Fax Number

The following Information-Please Check

- ☐ Immunization
- ☐ Medical History
- ☐ Labs-Specify Date(s) : _____
- ☐ Radiology-Specify Date(s): _____
- ☐ Gynecology-Specify Date(s): _____
- ☐ Other:_____

How would you like you your records: ☐ Printed Out ☐ Emailed: _____
☐ Mailed to Address Listed Above

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)

Clear form