

WAIVER FOR DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION

I hereby authorize Florida Southern College Student Health Center to release confidential health information, which may include laboratory results, immunization record, school physical, and record of clinic visits to the physician, ARNP, or RN from the health records of:

Student or former student's	name: (please print)	
Date of Birth:	Telephone Number:	
Covering the period of	to	
Sent To: 1. Myself		
2. Name:	Phon	e/Fax Number:
Address:		
3. Name:	Phon	e/Fax Sumber:
Address:		
The information to be disclos	sed is: (please initial all that apply)	
The front of the medic number, school physical, and	cal record which includes: student's name, a I immunizations.	address, Social Security number, phone
Laboratory test results	s X-ray results Consul	t report
Record of FSC Student	t Health Center clinic visits.	
I understand this authorization automatically expires in six n	on may be revoked at any time, except to the nonths.	extent already acted upon. This consent
I hereby release Florida Sout action I have authorized abo	thern College Student Health Center from a ve.	all legal liability that may arise from the
RECEIVES THIS INFORMATION	ATUTES AND FEDERAL REGULATIONS (42 ON FROM MAKING ANY FURTHER DISCLOS N CONSENT OF THE PERSON TO WHOM IT F	SURE OF THIS IN FORMATION EXCEPT
Date of authorization	Student/Former student signature	Social Security Number