CONSENT TO RELEASE MEDICAL RECORDS FROM USM STUDENT HEALTH SERVICES

NAME: _____

ID#: _____

DOB: _____

FROM: The University of Southern Mississippi Student Health Services
118 College Drive, #5066
Hattiesburg, MS 39406
601-266-5390
601-266-4205 (fax)

I authorize the release of my medical records to:

Name of provider, company, individual, etc. _____

Address: _____ Phone#: _____

_____ Fax #: _____

What ***EXACTLY* do you want copied and released:**

_____

_____

_____

PATIENT COUNSELED ON RECORD CONTENTS

I have read and fully understand the above releases and authorization is hereby acknowledged with my signature below.

_____ _____

Patient's signature Date signed

_____ _____

Witness signature Date signed

June 2016