CONSENT TO RELEASE MEDICAL RECORDS TO USM STUDENT HEALTH SERVICES

NAME: ____

ID#: ____

DOB: ____

FROM: ____

PHONE# :____

FAX #:____

ATTENTION TO: ____

I authorize the release of my medical records to:

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