



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

**Submit completed form to: FRANCISCAN UNIVERSITY
OFFICE OF HEALTH AND SAFETY
5414 Brittany Drive, Baton Rouge, LA 70808
phone (225) 768-1755 fax (225) 214-1945**

NAME AS IT APPEARS ON UNIVERSITY RECORD:

LAST FIRST MIDDLE

Other name(s) your record may be under: _____
Social Security Number: _____
Date of Birth: _____
Address: _____
Phone number: _____ Alternate phone number: _____

DATE OF INITIAL ENROLLMENT:
Semester: ___FALL ___SPRING ___SUMMER Year: _____
Graduation Date: _____
Program of Study: _____

Authorization to release health information

I hereby authorize Franciscan Missionaries of Our Lady University to release a summary of my student health information including immunization dates, dates and results of TB skin testing, date and result of Hepatitis B surface antibody test (if available), date of physical exam, dates of CPR certification, and provide such information to:

_ (You must provide contact information including address or fax number).

SIGNATURE DATE (Authorization expires 30 days from this date)

This section for Office Use:
Date received: _____ Date completed: _____
Comments: _____

