



SOUTH CAROLINA STATE UNIVERSITY
BROOKS HEALTH CENTER

"Good Health Comes First"

Authorization to RELEASE/OBTAIN Medical Information

I hereby authorize permission to obtain/release (circle) health, medical information and other necessary data in regard to:

NAME: DATE OF BIRTH:

ADDRESS (City/State/Zip Code):

STUDENT ID/*SSN: TELEPHONE:

* Provision of Social Security number is voluntary, is requested solely for administrative convenience and record-keeping

Information to be released or obtained:

- Progress/MD/Nurse Notes Consultation Report Laboratory Tests
History/Physical Immunization Record EKG report
ER Report Other

Record for the period (dates) from to

Obtain/Release Information : Name: Street: City, State, Zip: (Telephone/Fax):

TERM: I understand that I may revoke this authorization at any time. Unless otherwise revoked, this authorization will expire 90 days from the date of signature.

Signature of Patient or Legal Representative Date

Signature of Witness Date

Confidentiality Note

The information contained in this facsimile is legally privileged and confidential information intended only for the use of the individual or entity named above. If you are not the intended recipient or the employee or agent responsible for delivering this communication to the intended recipient, you are hereby notified that any reading, distribution or copying of this communication is strictly prohibited. If you have received this facsimile in error, please notify us immediately by telephone (803) 536-7053/7055.