



Samuel Merritt University
Student Health and Counseling Center
3100 Telegraph Avenue, Suite 3105
Oakland, CA 94609

Telephone (510) 879-9288 / Fax (510) 457-2627

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize **Samuel Merritt University Student Health Services** to:

release information to

Full Name of Physician, Clinic, Hospital

Street Address

City / State / Zip

Telephone # *Fax #*

Mail only Fax only Mail & Fax

Regarding treatment of:

Full Name of Student/Patient

Date of Birth *SS #*

Street Address

City / State / Zip

Please provide the following information:

Dates of Service:

Immunization History, specifically: _____

Laboratory Reports, specifically: _____

Radiology Reports, specifically: _____

Other, specify: _____

This authorization is valid for one (1) year from the date signed below, unless otherwise specified below.

Student Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Special Instructions: _____