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: _____