

Authorization to Release Health Records

Student Health Center – Louisiana State University
Infirmary Road – LSU Campus
Baton Rouge, LA 70803-2401
Phone 225/578-6271 Medical Records Fax 225/578-5282

Release authorized by: _____
(Please print) Name

_____ Address

_____ City State Zip

_____ Patient's ID Number

_____ Date of Birth

I authorize the release of my health records **from** the following institution or individual:

to the following institution or individual:

Purpose of authorization:

Specific information to be released:

Expiration date of authorization: _____

I understand this release may be revoked in writing at any time:

_____ Signature of Patient

_____ Date of Consent