AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Submit completed form to:

FranU
Health and Wellness
5414 Brittany Drive, Baton Rouge, LA 70808
phone (225) 526-1636 fax (225) 526-1945

NAME AS IT APPEARS ON UNIVERISITY 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 AT OLOLC:
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: _____

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