



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 UNIVERSITY RECORD:

LAST	FIRST	MIDDLE
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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: _____
