FLORIDA ATLANTIC UNIVERSITY
RELEASE OF MEDICAL INFORMATION FORM

RELEASE OF MEDICAL INFORMATION
To Verify authenticity of Medical Documents

I hereby authorize and instruct the physician named below to release all information from my medical records which pertain to my request for a medical withdrawal, to the Associate Vice President & Dean of Students Office of Florida Atlantic University.

PHYSICIAN NAME: _____

PHYSICIAN ADDRESS: _____

_____

_____

PHYSICIAN PHONE NUMBER: _____

STUDENT SIGNATURE: _____ DATE: _____

STUDENT NAME (Please Print):_____

STUDENT Z NUMBER: _____

THIS FORM MUST BE SUBMITTED IN CONJUCTION WITH THE "REQUEST FOR EXCEPTIONAL CIRCUMSTANCES WITHDRAWAL FORM".

THIS RELEASE IS IN COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND PRIVACY ACT (HIPPA).

THIS RELEASE IS GOOD FOR 90 DAYS FROM STUDENT'S DATED SIGNATURE ABOVE.

Completed forms with required documents must be returned to the
ASSOCIATE VICE PRESIDENT & DEAN OF STUDENTS OFFICE
FLORIDA ATLANTIC UNIVERSITY
777 GLADES ROAD
SSB# 8, ROOM 226, BOCA RATON, FL 33431
Fax: (561) 297-2502

Sept 2008