Nicholls State
University Health Services
P.O. Box 2054
Thibodaux, LA 70310
985.493-2600
Fax 985.493.2601

Name_____

Date_____

Student or Employee ID#_____

Date of Birth_____

AUTHORIZATION FOR RELEASE OF INFORMATION

I,_____ hereby authorize Nicholls State
patient's printed name
University Health Services to:

____ OBTAIN from ____ MAKE TELEPHONE CONTACT with

____ RELEASE to ____ CORRESPOND with by phone, email, via fax, etc.

_____
Name (Self, Person. or Agency)

_____
Address, City, State, Zip Code

_____
Telephone Number or Email address

a copy of the following:

____ Medical/Treatment records ____ Appointment Verification

____ Immunization Records ____ Other (please specify): _____

____ Ticket

for the purposes of _____

_____

All information I hereby authorize to be obtained from the agency will be held strictly confidential and cannot be released by the recipient without my written consent. It is further understood that information released is for professional purposes only and may not be provided in whole or part to any other agency, organization, or person other than stated above. I also understand and consent that this information may be sent via facsimile transmission. I understand that this authorization will remain in effect for:

_____ ninety (90) days, unless I specify an earlier expiration date_____
Date

_____ one (1) year

_____ the period necessary to complete all transactions on matters related to services provided to me

_____ _____
Date Signature of Patient

_____ _____
Date Signature of Witness