North Carolina Central University Name: _____ SS#:_____ Student Health and Counseling Services PO Box 19491 DOB: ____ Phone (919) 530-6317 Fax (919) 530-7969 **Authorization For Release of Medical Information** When requesting records from NCCU, please allow two working days for receipt of information. I authorize and request: (Facility and/or person releasing information) (Address, phone number and fax number) To release to: (Facility and/ or person receiving information, fax #) Information to be released (please check to indicate information requested): Immunization records Clinic notes Physical examination I understand that: 1) I may revoke this authorization at any time: a) The revocation will not apply to information that has already been

- released in response to this authorization
- b) I must revoke this authorization in writing
- 2) A fee may be charged for copying protected health information

Unless otherwise revoked, this authorization will expire in ninety (90) days from the date of signature.

I have read and understand the information in this authorization form.

Signature of Students X	Date
Witness X	
Legal Representative (if applicable) X	