AUTHORIZATION FOR RELEASE OF INFORMATION

VINCENNES UNIVERSITY
1002 N. First Street
Vincennes, IN 47591
Phone (812) 888-4655
Fax (812) 888-2295

I, _____ _____

Patient's Full Name Date of Birth

hereby authorize Vincennes University Immunizations to release my immunization records to:

Name of person/institution: _____

Street Address: _____

City/State/Zip Code: _____

Phone Number: _____

Fax Number: _____

The information is being authorized for release for the following reasons:

I understand this request shall remain valid unless revoked in writing, and that it is understood by all affected parties that all health information released prior to the notice of revocation was made with my authorization.

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by this authorization.

By signing this Authorization for Release of Information, I acknowledge that I have read and fully understand the terms and conditions of this authorization.

_____ _____

Patient's Signature Date

_____ _____

Address Telephone Number