



MEDICAL RELEASE REQUEST

DATE: _____

FROM: LONGEST STUDENT HEALTH CENTER
 BOX 9732
 MISSISSIPPI STATE, MS 39762
 PHONE 662-325-8846
 FAX 662-325-8888

I HEREBY AUTHORIZE THE RELEASE OF MY _____

OR COPIES OF SUCH AND REQUEST THAT THEY BE TRANSFERRED TO:

(NAME OF DOCTOR OR FACILITY OR PATIENT)

ADDRESS _____

CITY _____ STATE _____ ZIP _____

**NAME OF PATIENT _____
(PLEASE PRINT NAME ABOVE)

**DATE OF BIRTH _____ SOCIAL SECURITY _____

SIGNATURE _____
(PATIENT, PARENT OR LEGAL GUARDIAN)

RELATIONSHIP IF NOT PATIENT'S SIGNATURE _____
(PARENT OR LEGAL GUARDIAN)