MEDICAL RELEASE REQUEST

DATE: ______________________

TO: LONGEST STUDENT HEALTH CENTER
BOX 6338
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 FROM:

____
(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)

Records requested by:

Collins Mabry Watras McIntyre Crowley Rizer Fitts