## MEDICAL INFORMATION RELEASE FORM

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, , authorize

Print Name Year of Graduation

Randolph College

Health Center

2500 Rivermont Avenue

Lynchburg, VA 24503

Tel: 434-947-8130 Fax: 434-947-8106

\_\_\_\_\_to receive information from

**OR**

\_\_\_\_\_to release information to

Name

Address

Phone Fax

concerning:

**Specific expiration date or timeframe for expiration**

I understand that this authorization is subject to revocation at any time, except to the extent that the individual or entity that is to make the disclosure has already taken action in reliance upon it.

I also understand and agree that this authorization will terminate only upon the execution of my written statement indicating my intent to revoke this authorization and that without such written revocation, this authorization shall remain in full force and effect as specified in the expiration timeframe.

D.O.B.

Signature of Student

Signature of Witness March 2011