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MEDICAL RELEASE
CONSENT FORM

*(PLEASE COMPLETE **ENTIRE** FORM AND RETURN SO WE MAY FORWARD YOUR MEDICAL RECORDS.)*

I, _____, do hereby give my permission to have my medical records released from _____ and sent to:

NAME OF PERSON AND/OR AGENCY: _____

ADDRESS: _____

_____

PHONE: _____ FAX: _____

I would like my records: ❒ Faxed to above number ❒ Mailed to above address

I understand that my records are confidential and may be disclosed only as authorized in this consent.

Semester and year you *entered* Ferrum College _____

YOUR Current Phone Number: _____

_____ _____

Signature/Date Last four digits of Social Security Number