



LYNN UNIVERSITY

HEALTH CENTER

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E. Healthcenter@lynn.edu

Authorization for Use or Disclosure of Confidential Information

Name: Lynn ID#
Address: Phone Number:

I, hereby authorize Lynn University Health Center to (Choose one option)

- Use or disclose my Protected Health Information as indicated below.
Obtain my Protected Health Information from:
Exchange all pertinent, Protected Health Information pertaining to me with:

Name:
Address:
Telephone/Fax:

Indicate how you would like to receive the records

Pick up in person Mail to address noted Fax to #:

The following information from my medical records: (Circle all that apply)

Immunization Record Labs Most Recent Physical Exam
Depo injection history Other:

For the purpose of providing comprehensive treatment and coordination of services.

In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information. I further understand that revoking this authorization must occur in writing and can be done at any time.

Client Signature Date:

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