LYNN UNIVERSITY | HEALTH CENTER

3601 North Military Trail Boca Raton, FL 33431
Tel: 561-237-7231 Fax: 561-237-7116
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:_____