LEE UNIVERSITY
Health Services

RELEASE OF MEDICAL INFORMATION/ PRIVACY NOTICE FOR PROTECTED HEALTH INFORMATION

PATIENT'S NAME: _____ SS#_____
(PLEASE PRINT)

I do hereby give my permission for the Director of Lee University Health Clinic to discuss my medical condition with: **Please specify individuals and relationship to patient. (Please include Coaches, Professors, Campus Personnel, Parents, etc.)** **I understand that it is my responsibility to change or update this list as it becomes necessary.** Also, by signing this document I consent that I have read and understood the Notice of Privacy information given to me by the Lee University Health Clinic staff and now know how my personal information may legally be used as part of my health care.

_____ _____
Signature of Student / Patient **Date**

_____
Name Relationship to Patient

_____
Name Relationship to Patient

_____
Name Relationship to Patient

Please exclude the following information when discussing my care with those listed above:

_____

TREATMENT AUTHORIZATION

IMPORTANT: This form **MUST** be signed by a parent or guardian **IF** the patient is under age 18, **OR** by the patient if 18 or older in order to receive medical care by the Lee University Health Clinic.

I hereby authorize and give my consent to the health authorities of the Lee University Health Clinic Staff to perform any reasonably necessary medical treatment upon or administer medical care to:

_____
(NAME OF PATIENT)

This authorization is intended to cover emergency treatment, immunizations, injections, and minor procedures and care. This authorization is for treatment in the Lee University Health Clinic only. This permission is good only while the patient is attending the above university.

SIGNATURE _____DATE OF BIRTH_____
RELATIONSHIP TO PATIENT: SELF _____OTHER_____
TODAY'S DATE _____