Mary S. Shook
Student Health Service
APPALACHIAN STATE UNIVERSITY

Authorization to Release Patient Medical Information to ASU Student Health Services

I understand that my medical records are confidential and cannot be disclosed without my written consent unless otherwise authorized or required by law.

I hereby authorize and request disclosure of the following health records be submitted to:

Mary S. Shook Student Health Services
ASU Box 32070
Boone, NC 28608
Fax: 828-262-6958

Attn:_____

I understand the confidentiality of my medical records cannot be guaranteed by the Mary S. Shook Student Health Services if the records are disclosed by facsimile (FAX).

I agree to indemnify and save harmless Appalachian State University and its trustees, agents, and employees from all liabilities, losses, costs, damages, claims or causes of action on any kind or nature whatsoever, and expenses, including attorneys' fees, arising or claimed to have arisen out of any injuries or damages received or sustained by any person(s) or property, as a result of intentional acts or omissions of Appalachian State University or its trustees, agents, or employees, or of negligence on the part of Appalachian State University trustees, agents, or employees, in the execution, performance, or enforcement of this agreement.

Report(s) Requested

(Please initial beside of the appropriate reports)

			Pts Initial
☐ Medical History			_____
☐ Immunization Records	☐ All	☐ Type_____	_____
☐ Laboratory Report(s)	☐ All	☐ Type/Date_____	_____
☐ X-Ray Files/Report(s)	☐ All	☐ Type/Date_____	_____
☐ Letter/Medical Statement	Type/Date_____		_____
☐ Other _____	Type/Date_____		_____

PATIENT INFORMATION

Name (Please Print):_____ ASU Banner ID:_____

Telephone #:_____ Last Semester at ASU:_____

Date of Birth:_____ Patient Signature_____

Date Requested:_____ Witness:_____

This authorization will remain in effect for 60 days and may be revoked at any time.