EMBRY-RIDDLE
Aeronautical University

PRESCOTT, ARIZONA

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
ERAU WELLNESS CENTER
(928) 777-6653 or Fax (928) 777-3850

I Authorize _____
Name of sending agency or institution

_____
Address

_____
City State Zip

To Release to: **ERAU WELLNESS CENTER**
3700 WILLOW CREEK ROAD
PRESCOTT, AZ 86301-3720

The Following information: (info to be release must be clearly specified)

In regards to _____ __/__/__
(PRINT) Name of patient at time of treatment Date of birth

For the purpose of _____

I understand that I may revoke this consent at any time except to the extent that action had been taken based on this authorization. I also understand that this authorization shall expire, without my expression revocation, three months from the date written below.

_____
Signature of patient or responsible person Date

Witness Date