PLYMOUTH STATE UNIVERSITY-Global Education Office-Limerick
Authorization for the Release of Medical Records Information

I, _____, hereby grant to Plymouth State University Health Services, as well as to physicians in private practice, in advance of my participation in a study away program and in anticipation of the possibility that I may require medical attention while away, permission to release upon written request [that may be accomplished by Fax machine] from any hospital, clinic, or physician, any and all medical records concerning me in the custody of Plymouth State University Health Services or in the custody of private practitioners. This authorization is effective upon my departure date of 09/01/2014, and shall remain in effect until the date of my return, 12/20/2014.

Student Signature:_____ Date:_____

Print Full Name:_____

If the Student is under 18 years of age, this must be signed by the Student's parent or legal guardian:

Parent or Legal Guardian Signature:_____ Date:_____

Print Full Name:_____

Submit this form to:
Plymouth State University: The Global Education Office
MSC 44, 17 High St., Plymouth, NH 03264, Tel: 603-535-2336, Fax: 603-535-2528