EMPLOYEE HEALTH

Please complete and email to EmployeeHealthRecord@miami.edu

UNIVERSITY OF MIAMI
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS FORM

Patient information (PRINT)

Last Name:_____First Name: _____Date of Birth: _____

C# or Workday# _____ Mobile Phone# _____

Address:_____City:_____State:_____Zip Code: _____

RELEASE MY MEDICAL RECORDS FROM:

University of Miami
Employee Health Office (R-23) Suite 405,
1400 NW 10th Ave Miami, FL 33136
Phone: (305) 243-3400
Fax: (305) 243-2393

RELEASE MY MEDICAL RECORDS TO: ☐

NAME (Institution or self): _____

TELEPHONE: ( )_____ FAX: ( ) _____

CHECK THE APPROPRIATE BOX:
Please release a copy of my:

- ☐ Immunization record
- ☐ Laboratory result
- ☐ TB skin test result
- ☐ Chest x-ray result
- ☐ Flu Vaccine
- ☐ Other_____

BY MY SIGNATURE BELOW, I AUTHORIZE RELEASE OF MY MEDICAL RECORDS

Full Name: _____**Date:** _____

EMPLOYEE HEALTH OFFICE (R-23), Dominion Tower, Suite 405.Office: (305) 243-3400. Fax: (305) 243-2393

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