For Office Use Only
[ ] Mailed (date) _____/_____/____(initial) ____
[ ] Faxed (date_____/_____/____ (initial) ____
[ ] Emailed to student (date)_____/_____/____ (initial) ___

Formerly FileMD

AUTHORIZATION FOR RELEASE OF ACTIVE STUDENT MEDICAL INFORMATION

- **Once your authorization is received by Sentry MD, there is a 24 to 72 hour processing time.**
- **One authorization is to be filled out per facility.**
- **Sentry MD can ONLY email records to the student. Sentry MD will not email your records to clinical sites of any kind.**

I,_____, authorize Sentry MD to disclose
Student Name (PRINT)
the following copies of my _____ school health records:
Name of school you attend

Choose one of the following by placing an "X" next to the type you want

_____ All copies that are contained in my school health record (*Includes all records on file)*
_____ **ONLY** Summary of Immunization Data

Please indicate how you wish the forms to be sent by placing an "X" next to the delivery method:

[ ] faxed [ ] mailed or [ ] emailed (to the student only, cannot email to institutions)

_____ At _____
Name of Individual Receiving Forms ***Name of Organization/Location***

(_____)_____ (_____) _____-_____
Organization's Phone # ***Organization's Fax #***

_____
Address to mail requested information

_____@_____
Email Address to email requested information (Sentry MD can ONLY email students their records)

_____
For the purpose(s) of

I understand that I may revoke or amend my authorization in writing at any time, but that I may not hold Sentry MD responsible for acting in reasonable reliance on this statement prior to the time that it learns of my revocation or amendment.
This authorization is valid for three months from the date signed.

_____ _____/_____/_____
Student's Signature **Date of Signature**

_____ _____/____/_____
Student Email Address **Date of Birth**

RETURN TO: Sentry MD
Fax: 817.251.9593 and 214.619.1830
Email: universitystudent@sentrymd.com