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

SENTRY MD
Formerly FileMD

AUTHORIZATION FOR RELEASE OF TERMINATED STUDENT MEDICAL INFORMATION

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

The annual fee for continuing Sentry MD services, including unlimited releases of medical information you request and on-going assistance and maintenance of your health/immunization records is $20/year. Your membership will be billed annually and may be canceled at any time. The fee for a one time release of your medical records is $25. Please indicate your preference:

[ ] on-going membership for $20 [ ] one-time release for $25

Once we receive this form you will be emailed an invoice via PayPal.

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 individual requesting the records 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

NOTE:

- **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 or employment sites of any kind.**

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