AUTHORIZATION FOR RELEASE OF STUDENT MEDICAL INFORMATION

- **Once your authorization is received by Sentry MD, there is a 24 to 72-hour processing time.**
- **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

*(Initial)*_____All copies that are contained in my school health record (*Includes all records on file) to the below email address.*

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

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

Email: universitystudent@sentrymd.com

For Office Use Only

☐ Emailed to student (date)_____/_____/_____(initial) _____