UNIVERSITY OF MONTEVALLO HEALTH CENTER
MEDICAL RELEASE
TELEPHONE: (205) 665-6275
Fax: (205) 665-8180

(PLEASE PRINT)

NAME:_______________________________________

SS# or ID#_____________________________________

DOB:____

DATE:____

TELEPHONE:_________________________________

I,____,

DO HEREBY GIVE THE UNIVERSITY OF MONTEVALLO STUDENT

HEALTH CENTER MY PERMISSION TO RELEASE MY HEALTH

RECORD TO:

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SIGNATURE

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WITNESS