THE UNIVERSITY OF
SOUTHERN MISSISSIPPI

MOFFITT HEALTH CENTER

118 College Drive #5066 | Hattiesburg, MS 39406-0001
Phone: 601.266.5390 | Fax: 601.266.4205 | clinicadmin@usm.edu | www.usm.edu

Consent to Release Medical Records
TO Moffitt Health Center

NAME: _____
USM ID#: _____ DOB: _____

FROM: _____
Address: _____
Phone #: _____ Fax #: _____

I authorize the release of my medical records to:

The University of Southern Mississippi
Student Health Services at Moffitt Health Center
118 College Drive, #5066
Hattiesburg, MS 39406
601-266-5390
601-266-4205 (fax)

What *EXACTLY* do you want copied and released:

_____
_____
_____

PATIENT COUNSELED ON RECORD CONTENTS

I have read and fully understand the above release and authorization is hereby acknowledged with my signature below.

_____ _____
Patient Signature Date Signed

_____ _____
Witness Signature Date Signed

Accredited by
AAAHC
ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.