FIU | Academic & Student Affairs

Health Compliance

Phone: (305) 348-2688 | **Fax:** (305) 348-3336

AUTHORIZATION FOR RELEASE OF IMMUNIZATION INFORMATION

I, ___________________________________, hereby authorize FIU Health Compliance to release (mail and/or fax) immunization information from my records to:

Name: ____

Address: ____

City: ____ State: _________________ Zip Code: ______________

Phone: ____ Fax: ___________________________________

Email: ____

The purpose or need for the information is:

______ Proof of immunization for school

______ Other (specify) ____

I may be contacted at the following number: ____

I understand that this authorization is valid for 90 days after the date of my signature. I also understand that this authorization can be revoked, except to the extent that action has already been taken to comply with it. Information documented in my record after the date of my signature will not be released.

***Photo ID must be attached to this form.**

__________	___________	____
Date	Panther ID	Signature of Student or Legal Guardian (if under 18 years)

_________________________	____
Date of Birth	Legal Representative's relationship to Student

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Date released from FIU Health Compliance: ______ / ______ / _______

Sent via: ☐Fax ☐Mail ☐Email **Initials:** ____________________________

11/19/21