VALDOSTA STATE UNIVERSITY
Center for Exercise Medicine & Rehabilitation
Valdosta, Georgia

Wellness and Fitness

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. I hereby authorize _____ to release the following information from the medical record of

   Patient's name _____
   Address _____
   Telephone _____
   Date of Birth _____

2. Information to be released (please specify):
   _____
   _____

3. Information to be released to:
   Valdosta State University: Center for Exercise Medicine & Rehabilitation

4. Please send correspondence to:

   Lindsay Freidhoff, MS, ACSM-EP-C, EIM-II
   Director, Center for Exercise Medicine and Rehabilitation
   School of Health Sciences
   College of Nursing and Health Sciences
   Valdosta State University
   1500 N. Patterson Street
   Valdosta, GA 31698
   229.532.2887 (phone)
   229.259.5129 (fax)
   lrfreidhoff@valdosta.edu

5. Purpose of disclosure information: _____

6. I do not give permission for disclosure or redisclosure of this information other than that specified above.

I understand that this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

Patient Name	Signature	Date
_____	_____	_____

Thank you for your continued support of VSU and the Center for Exercise Medicine and Rehabilitation!