MEDICAL RELEASE

NAME: _____

ID#: _____

DATE OF BIRTH: _____

REASON FOR MEDICAL RELEASE: _____

_____

_____

_____

_____

NAME OF PHYSICIAN: _____

PHONE NUMBER: _____

ADDRESS: _____

_____

I hereby authorize the above captioned physician to release my medical history and condition to determine if off campus housing is warranted to:

Albany State University
Housing and Residence Life
504 College Drive, Hall #3
Albany, GA 31705
(229) 430-4741
FAX (229) 430-2790

NAME: **_____** ***DATE:*** **_____**
(Please Print)

SIGNATURE: **_____**