

Date \_\_\_\_\_

## MEDICAL INFORMATION RELEASE FORM

816-584-6257  
FAX # 741-1103  
f

I, \_\_\_\_\_, authorize

Print Name

Park University  
Ellen Finley Earhart Nursing Program  
PMB # 52  
8700 N. W. River Park Drive  
Parkville, Mo. 64152  
Tel: 816-584-6257 Fax: 816-741-1103

to receive information from

**OR**

to release information to

Name _____
Address _____
_____
_____
Tel: _____

Concerning: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I am requesting this information be sent by way of : **(CHECK ONE ONLY)**

- Mail
- E-mail
- Fax
- In person

Student Signature	
Student's Park ID # or Social Security #	