

**AUTHORIZATION FOR RELEASE  
OF MEDICAL INFORMATION**

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

FAX Number: \_\_\_\_\_

Medical Condition: \_\_\_\_\_

Your signature on this release authorizes the Angelo State University Office of Residential Programs to mail a questionnaire to the above named physician. This questionnaire will request detailed information on the medical condition listed above and how the problem will be alleviated by off-campus housing.

This release further authorizes the ASU physician to contact the above named physician to discuss any questions about the information the above named physician provides on the questionnaire.

\_\_\_\_\_  
Student's Name

\_\_\_\_\_  
Campus ID Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date

*The information you have supplied on this form is maintained by the University.  
You have the right to review and correct this information by contacting the Office of Residential Programs.*

**FOR RESIDENTIAL PROGRAMS OFFICE USE ONLY**

Date Application Received by Residential Programs Office: \_\_\_\_\_

Date Questionnaire FAXED to Above Named Physician: \_\_\_\_\_

Date Completed Questionnaire Received from Above Named Physician: \_\_\_\_\_