**Office of Student Health Services** **Office: (504) 520-7396**
**1 Drexel Drive Box 36** **Fax: (504) 520-7962**
**New Orleans, La.70125**

**Authorization for Release of Health Information to Xavier University**

**Patient Information:**

**Name: _____** **D.O. B. _____/_____/_____**

**ID# or SSN: _____** **Phone #: _____**

I authorize _____ to release a copy of my medical

information to **Xavier University of Louisiana, Office of Student Health Services, 1 Drexel Drive, Box 36, New Orleans, LA. 70125.**

**Method of Delivery:**
**US Mail** - 1 Drexel Drive, Box 36, New Orleans, LA. 70125
**Fax** (504)520-7962