

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

DATE: \_\_\_\_\_

TO WHOM IT MAY CONCERN:

You are hereby authorized to give to:

State of Louisiana	<i>AND / OR</i>	Southeastern Louisiana University
Office of Risk Management		Human Resources Office
P.O. Box 91106		SLU 10799
Baton Rouge, Louisiana 70821-9106		Hammond, Louisiana 70402

any and all information which may be requested regarding my medical treatment rendered, and furnish to them full reports and copies of records which you have regarding my condition, treatment, etc.

I am willing that a photostat of this authorization be accepted with the same authority as the original.

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Print Name (Employee)**

\_\_\_\_\_  
**Witness Signature**

\_\_\_\_\_  
**Print Name (Witness)**