AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

- **Once your authorization is received by Sentry MD, there is a 24 to 72-hour processing time.**
- **Sentry MD can ONLY email records to the member associated with the Sentry MD account. Sentry MD will not email your records to any outside parties.**

I,_____, authorize Sentry MD to disclose
Name (PRINT)
all copies from my account with Sentry MD to my email address at _____@_____.

I understand that I may revoke or amend my authorization in writing at any time, but that I may not hold Sentry MD responsible for acting in reasonable reliance on this statement prior to the time that it learns of my revocation or amendment.

This authorization is valid for three months from the date signed.

_____ _____/_____/_____
Member Signature **Date of Signature**

_____ _____/_____/_____
Member Email Address **Date of Birth**

RETURN TO: Sentry MD as a signed PDF attachment to Info@SentryMD.com

For Office Use Only

[ ] Emailed to student (date)_____/_____/_____(initial) _____