**THE UNIVERSITY OF MISSISSIPPI**
**LABORATORY SERVICES**
Phone (662) 915-5433 FAX (662) 915-5480

**AUTHORIZATION TO RELEASE RADIATION EXPOSURE INFORMATION**

Date: _______________

To: ______________________________________
______________________________________
______________________________________
______________________________________

You are granted permission to transfer to W. Scott Rone, Radiation Protection Specialist of the University of Mississippi, all information concerning my radiation exposure history while I was employed or assigned at _____________________________during the period from ____/_____/_____ to _____/_____/_____.

You are authorized to include in you transfer all information concerning my radiation exposure history acquired by you from other persons, employers, or agencies, if such records are in your possession. Please transmit my radiation exposure record to the above office.

Name: __________________________________________

Social Security Number: ______ / ______ / __________

Birthdate: _______ / _______ / _______
Month Day Year

Sincerely yours,

______________________________________
(Signature)