OKLAHOMA STATE UNIVERSITY
CENTER FOR HEALTH SCIENCES
COLLEGE OF OSTEOPATHIC MEDICINE
1111 West 17th
Tulsa, OK 74107

AUTHORIZATION FOR RELEASING RADIATION EXPOSURE INFORMATION

TO:

FROM:

ADDRESS:

DATE:

You are hereby granted permission to make available to the person I have indicated below, any or all information concerning my radiation exposure history as developed while I was employed or assigned at _____ during the period from _____ to _____. You are further authorized to include in your transmittal to said person, any or 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:

Radiation Safety Officer
Research Office
Oklahoma State University
Center for Health Sciences
1111 West 17th
Tulsa, OK 74107

Special instructions: _____

_____

_____

_____
Signature radiation worker

_____
Signature Radiation Safety Officer-OSUCHS