UTICA COLLEGE
Student Health Center
1600 Burrstone Road
Utica, NY 13502
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

NAME: ____DOB: ___/__/___START________
Last First Middle Mo. Day Yr YEAR

STUDENT ID # _________________CURRENT ADDRESS:_________________________

PHONE/CELL# _______________________ ________________________

I hereby authorize and request the release of my records from _______________________

Phone #______________Fax#_______________Address:___________________________
To be forwarded to:

NAME: ____

STREET: ____

CITY, STATE, & ZIP: ____

PHONE: ____________________________ FAX#________________________

Release the following:

____Immunization Records ____Lab/Test Reports

____Most Recent Physical Exam ____GYN Records

____PPD Results ____Progress Notes

____Flu Vaccine ____X-ray Reports

____Other (state specific portions of medical record desired)_____________________________

PATIENT SIGNATURE:_______________________________DATE SIGNED:_________

WITNESS SIGNATURE:_______________________________DATE SIGNED:_________