MEDICAL INFORMATION RELEASE FROM TC3

Tompkins Cortland Community College

Health Center

Date _____

Student Name: _____
Last (include Maiden Name) First Middle Initial

Phone Number: (____)_____ Date of Birth: _____
mm / dd / yyyy

Student ID Number: 7_____

I authorize and request TC3 to release my

❑ Medical ❑ Immunization

records to myself:

_____
Name

_____
Street Address

_____
City, State, Zip Code

_____
Fax #

records to a specific place:

_____
Name of place

_____
Street Address

_____
City, State, Zip Code

_____
Fax #

I understand that I may revoke this consent at any time except to the extent that action has already been taken on it and that it will expire automatically one (1) year from the date indicated below.

NOTE: Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR, part 2.

_____ _____
Student Signature *Witness Signature (witness must be 18 or older)

***A witness signature is mandatory for release of information.**

TC3 Student Health Center
170 North Street
P.O. Box 139
Dryden, NY 13053

Fax Number: (607) 844-6533

E-mail: healthcenter@tc3.edu