Student Health Center

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO TC3

Student Name: _____ Phone Number: _____

Student ID #: _____ Date of Birth: _____

I authorize and request

_____
(Name of university or physician RELEASING information.)

_____
(Street Address)

_____
(City, State, Zip Code)

to release my:

- ☐ Immunization records
- ☐ Medical records

TOMPKINS CORTLAND COMMUNITY COLLEGE
Attn: Student Health Center
170 North Street
Dryden, NY 13053
Phone: (607) 844-8222 Ext. 4487
Fax: (607) 844-6533

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.

_____ _____
Signature of Student Date