AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO Tompkins Cortland Community College Health Services

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

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

Student ID #: 7_____

I authorize and request

_____
(Name of university or medical office RELEASING information.)

_____
(Street Address)

_____
(City, State, Zip Code)

_____
Fax

to release my:

☐ Immunization records ☐ Medical records

To:

TOMPKINS CORTLAND COMMUNITY COLLEGE
Attn: Health Services
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 mm/dd/yyyy