GENESEE COMMUNITY COLLEGE
HEALTH CENTER
TELEPHONE: (585) 345-6835
FAX: (585) 345-6816

CONSENT TO RELEASE MEDICAL RECORDS

Student Name: _____
(Please Print) Last First Middle

_____
Maiden/Previous Name(s) – (if applicable)

Date of Birth:_____ **Telephone**: _____

Social Security # or Student ID # _____

Address: _____
Street

_____
City State Zip

I hereby authorize the Genesee Community College Health Center, to release the following information:

_____ Immunization Records
_____ Other (Please Specify) _____

Please Fax To: _____
Name of Agency

Attention (if known) _____ Fax: _____

or

Please Mail To: _____
Name of Agency

_____
City State Zip

or

Release to Student: (Please Specify)_____ send copy to student address stated above

or

Student to pick up copy on _____
Date

I authorize my medical information to be released as indicated above. I waive any claims against the sender concerning the communication and disclosure of such information.

I understand that my request will be processed within 48-72 hours.

Signature: _____ **Date**:_____