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: _____

GCC ID # or SS#: _____

Address: _____
Street

_____
City State Zip Code

I hereby authorize the Genesee Community College Health Center to release my immunization records.

Please **FAX** To: _____

Attention (if known): _____ Fax: _____

Or

Please **MAIL** To: _____

_____
City State Zip Code

Or

Release to: (Please Specify) _____

I authorized 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: _____