

Student Health

Return To:
Student Health
Services



Office Use Only

Re: _____
Sent: _____
Rec. By _____

**STUDENT HEALTH
RELEASE OF INFORMATION**

I _____ Date of Birth _____ Social Security Number _____

authorize Student Health Services of Davis College to :

Release **Obtain** (circle one)

a copy of the following portions of my medical /health record :

- _____ Immunization Record
- _____ Physician's Evaluation
- _____ Personal Medical Report
- _____ Other (please specify) _____

Please **RELEASE** information to: _____
(Name)

(Address if other than self)

Phone: _____ Fax: _____

Please **OBTAIN** information from: _____
(Name)

(Address)

Phone: _____ Fax: _____

Received: _____

Signature

Sent: _____

Date