

**MEDICAL INFORMATION
RELEASE
FROM TC3**



Date _____

Health Center

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

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

Student ID Number: 7 _____

I authorize and request TC3 to release my

Medical Immunization

records to myself:

records to a specific place:

Name

Name of place

Street Address

Street Address

City, State, Zip Code

City, State, Zip Code

Fax #

Fax #

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.

Student Signature

*Witness Signature (witness must be 18 or older)

***A witness signature is mandatory for release of information.**

**TC3 Student Health Center
170 North Street
P.O. Box 139
Dryden, NY 13053**

Fax Number: (607) 844-6533

E-mail: healthcenter@tc3.edu