

# MEDICAL INFORMATION RELEASE FROM TC3



## Health Center

Date \_\_\_\_\_

Student Name: \_\_\_\_\_  
First Last (include Maiden Name) 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:

\_\_\_\_\_  
(Name of university, physician, workplace, or "To Self" to release to yourself)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City, State, Zip Code)

\_\_\_\_\_  
(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.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Signature of Witness (must be 18 or older)

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

**Fax Number: (607) 844-6533  
E-mail: [healthcenter@tc3.edu](mailto:healthcenter@tc3.edu)**