DUTCHESS
COMMUNITY COLLEGE

HEALTH OFFICE

AUTHORIZATION FOR RELEASE OF MEDICAL/IMMUNIZATION RECORDS
(HIGH SCHOOL/PHYSICIAN/MILITARY OR OTHER DOCUMENTED RECORDS)

O Immunization Records____

O Physical ____

O Laboratory /Bloodwork ____

O Other: (specify) ____

Student Name (please print) ____

Student ID # ____

Purpose or Need for Information ____

Address/Fax # Where Records Are to Be Sent ____________________________________

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The College Health Office and its employees are hereby released from all legal responsibility or liability for the release of the records to the extent indicated and authorized herein.

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS:

______________________________ ______________________
Signature of Student Date

______________________________ ______________________
Witness Date

PH: 845-431-8075 FAX: 845-431-8504
SSB ROOM 110