Medaille College Health Center

I authorize the Medaille College Health Center to release my immunization records.

Name: _____

Name when attending Medaille College, if different from above:

_____

Address: _____

_____

Date of graduation or attendance _____

Phone _____

D.O.B. _____

SS # _____

Date _____

I waive any claims against the College and Health Service concerning the communication and disclosure of such information.

Signature _____

Please send them to:

Institution: _____

Address: _____

_____

_____

Fax: _____