COLLEGE HEALTH SERVICE

Authorization for Disclosure

NOTE: We Must See Proof of Identification To Allow Disclosure.

1. I, _____herby authorize Hudson Valley Community
   Please print your name
   College to release the following (circle one):

   Immunization Records,

   Physical Exam Record (if available),

   Treatment Records, including laboratory or x-ray information

   Other Information (please list) _____

   Concerning the following condition and/or related date of service
   _____

2. Name, address and if applicable, fax number of person or organization to whom this information is to be released: _____

   _____

   _____

3. Purpose of Disclosure: _____

4. I understand this is a consent for a one time disclosure only and that the requested information will be released within five (5) working days of the request. I further understand that I may revoke this consent anytime before the disclosure has occurred.

   I wave any and all claims against Hudson Valley Community College and the College Health Service in connection with the communication and disclosure of such information as requested.

5. Signed at Hudson Valley Community College this _____day of _____20____

   Signature _____

   Social Security Number _____

   Address _____

FOR HEALTH SERVICE USE ONLY

Witness _____Date _____

Released by: _____Date:_____ ***Form:*** letter fax e-mail other_____