



**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION \*\*TO WCSU HEALTH SERVICE**

Name: (Print) \_\_\_\_\_ WCSU ID #: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Telephone: \_\_\_\_\_

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

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

I hereby authorize (Name of Facility) \_\_\_\_\_

to release **to Western Connecticut State University Health Service** the medical information indicated below.

\_\_\_\_\_ Immunization Information (specify): \_\_\_\_\_

\_\_\_\_\_ Physical Exam/Health Record Report (*date if known*): \_\_\_\_\_

\_\_\_\_\_ Gynecological Exam and Tests (*dates*): \_\_\_\_\_

\_\_\_\_\_ Laboratory Tests / Results (*dates*): \_\_\_\_\_

\_\_\_\_\_ Other (*specify*): \_\_\_\_\_

I understand that this information shall remain strictly confidential and shall not be further relayed in any  
any other way to any other person or agency without an additional authorization by me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_