



Matthias Student Health Center
Phone: 315.684.6078 • Fax: 315.684.6493

PATIENT NAME _____ LAST SEMESTER ATTENDED Mo__Yr__

ADDRESS _____

CITY, STATE, ZIP _____

TELEPHONE _____ SS# _____ DOB _____

I, _____, do hereby grant authorization to Morrisville State College Student Health Center to fax or mail: **(PLEASE CIRCLE ONE)**

____ Release to: _____

____ Obtain from _____

FAX # and/or address for above _____

Please release the specific information described below:

____ Immunization records _____ Pap exam and results

____ Physical Exam _____ X-ray reports from _____

____ Lab reports from: _____ Other _____

____ Progress notes from: _____

I understand that in accordance with Federal and State laws, this release does not include permission to transmit information specifically related to H.I.V. (Human Immunodeficiency Virus, the causative agent of AIDS) status, and if such information is to be released, additional specific release forms are required. I understand that this consent is valid for ninety (90) days from the date of signing, and that I may rescind this consent at any time with written notification.

Signature of Patient/Student

Signature of Witness

DATE

DATE

06/05