



**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION \*\*FROM WCSU**

***PLEASE ALLOW 3-5 business days for processing***

Name At Time of Enrollment (Print) \_\_\_\_\_ ID # \_\_\_\_\_

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

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

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

Graduation Date \_\_\_\_\_ **OR** Last Semester Attended \_\_\_\_\_

CIRCLE: Full Time **OR** Part Time

**I Hereby Authorize The Release Of Information From My Medical Records Pertaining To My:**

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

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

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

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

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

**CIRCLE: Mail OR Fax to:**

Name (Print) \_\_\_\_\_

Address \_\_\_\_\_

**Fax Number** \_\_\_\_\_

I understand that this information shall remain strictly confidential and shall not be further relayed in any way to any other person or agency without an additional authorization by me. I understand that I may withdraw this authorization at any time prior to the release of the above information. This authorization will expire sixty days (60) after the date it is signed.

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

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

For Health Service Use Only

Date Completed \_\_\_\_\_ By \_\_\_\_\_