Western Connecticut State University
Health Service
181 White Street
Danbury, CT 06810
FAX (203) 837-8583

Consent for Release of Immunization Records

Name (Please print): _____

Date of Birth: _____ Student ID: _____

Phone: _____

I authorize the release of my immunization records as indicated below.

Signature: _____ Date: _____

Please select one of the choices below to indicate how you would like to receive your immunization record:

- ❑ ***Pick up at Health Service***
- ❑ ***mail to your home***

Address: _____
_____
_____

- ❑ **mail or fax to a designated college or university**

University: _____
Address: _____
_____
_____
FAX: _____

For Health Service use only

Date Completed: _____ Initials: _____