TROCAIRE COLLEGE

CONSENT TO RELEASE MEDICAL INFORMATION

Allow two weeks, upon receipt, for processing. This authorization will automatically expire within one year from the date of signature. I understand that I have the right to revoke this authorization in writing at any time, except where information has already been released in response to this authorization. **Please note this form requires a hand-written signature along with a copy of a valid picture identification.**

Student Information

Name_____ Date of Birth_____

Telephone Number_____

I hereby request and authorize Trocaire Wellness Center to Release information to:

Recipient Information

Name of person or Facility _____

Full mailing address_____

Telephone Number_____ Fax Number_____

Nature of Consent

☐ I consent to the release of Health/Immunization records which may include TB results including any related laboratory and/or radiology reports

☐ I consent to the release of medical records with the following exceptions: (Specifically describe the information you DO NOT wish to be released):

_____

_____

I consent to the release of medical information to the extent stated above.

Signature of Student_____ Date_____

Contact Information

Wellness Center
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