**REQUEST FOR RELEASE OF MEDICAL INFORMATION**

**AUTHORIZATION**

**WELLNESS CENTER**

**HEALTH RECORDS – ROOM 118**

**P: 716- 827-2489 or 716-827-2579**

**F: 716-825-0416**

**Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maiden Name if Applicable\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I hereby authorize\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (College, Health Facility, Physician, etc.)**

**to release to Trocaire College the following records concerning me:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Immunizations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health History**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physical Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ other (please specify)**

**I waive any claims against sender concerning the communication and disclosure of such information.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please scan/email to the** [**wellnesscenter@trocaire.edu**](mailto:wellnesscenter@trocaire.edu) **or fax at 716-825-0416**

**Mail to Health Records, 360 Choate Ave, Buffalo, NY 14220.**