TROCAIRE COLLEGE

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 or fax at 716-825-0416
Mail to Health Records, 360 Choate Ave, Buffalo, NY 14220.

MAIN CAMPUS
360 Choate Avenue
Buffalo, NY 14220
716-826-1200

2262 Seneca Street
Buffalo, NY 14210
716.826.1200

EXTENSION CENTER
6681 Transit Road
Williamsville, NY 14221
716-827-4300