Release of Medical Information from Tompkins Cortland Community College Health Services

Date _____
mm/dd/yyyy

Student Name: _____
Last (include Maiden Name) First Middle Initial

Phone Number: ( ) _____ Date of Birth: _____
mm / dd / yyyy

Student ID Number: 7_____

Medical Immunization records

to myself:

_____
Name

_____
Street Address

_____
City, State, Zip Code

_____
Fax #

to a specific place:

_____
Name of place

_____
Street Address

_____
City, State, Zip Code

_____

_____ _____
Student Signature *Witness Signature (witness must be 18 or older)

*A witness signature is mandatory for release of information.

Tompkins Cortland Community College Health Services Phone: 607-844-8222 x4487 FAX: 607-844-6533
E-mail: healthcenter@tompkinscortland.edu