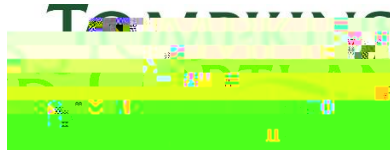


Release of Medical Information from Tompkins Cortland Community College Health Services



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.