NIAGARA COUNTY COMMUNITY COLLEGE
3111 Saunders Settlement Road, Sanborn, NY 14132
WELLNESS CENTER
TELEPHONE: (716) 614-6275
FAX: (716) 614-6817

CONSENT TO RELEASE MEDICAL RECORDS

Student Name: ____
(Please Print) Last First Middle

______________________________ ____________________________
Birth Nr./2M86-(66.0 3)T ____ -4.72 Mplttddl 3 N DddlBi

Address: ____
Street City State, Zip

Telephone No.__________________________ **Student ID No**.______________________

I hereby authorize Niagara County Community College, Wellness Center, to release the following information:

_________ Immunization Records with laboratory reports if applicable
_________ Other (Please Specify) ____

Please Check One:

☐ **Mail To:** Address As Above

☐ **Mail To:** Name of Agency: ______________________________ Attention: _________________

Address: ____
Street City State, Zip

☐ **Fax To**: Name of School or Agency: ____

Fax Number: ______________________________ Attention: _________________

☐ **Pick-Up**

I authorize my medical information to be released as indicated above. I understand this release is effective for 60 days from the date of request. I waive any claims against the sender concerning the communication and disclosure of such information.

I understand that my request will be processed within 5 business days.

Signature: ____ **Date:** ________________

Revised 01 2019