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 Name - (if applicable) Date of Birth

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:** _____