Student Health
Return To:
Student Health Services

Office Use Only
Re: _____
Ap: _____
Ac: _____

400 Riverside Drive, Johnson City, NY 13790
607.729.1581 ext. 337 • Fax: 607.584.7656 • health@davisny.edu

Health Services Release Of Information

I_____ Date of Birth_____ Social Security Number_____
Authorize Student Health Services of Davis College to:

Release **Obtain** (Circle One)

a copy of the following portions of my medical/health record:

_____ Immunization Record

_____ Physician's Evaluation

_____ Personal Medical Report

_____ Other (please specify) _____

Please **RELEASE** information to: _____
(Name)
_____
(Address if other than self)
_____

_____

Phone: _____ Fax: _____

Please **OBTAIN** information from: _____
(Name)
_____
(Address)
_____

_____

Phone: _____ Fax: _____

Received: _____ _____
(Signature)
Sent: _____ _____
(Date)