Rensselaer | STUDENT HEALTH CENTER

RELEASE OF INFORMATION

Name _____ Date _____

RIN _____ Date of Birth _____

Phone _____ Last at Rensselaer _____

Release to _____

Address _____

Fax/Email _____

I give the Student Health Center permission to release the following information to the person or group listed above (initial where applicable)

_____ Report of Medical History Form

_____ Immunization Record

_____ Laboratory Records of _____
(date/test)

_____ Information regarding this illness or incident (describe):_____
Note: You will need to fill out another Release of Information Form for each illness or incident.

_____ Medical Record ☐ complete ☐ selected summary _____
Note: there is a $0.75 per page charge for medical records

_____ Other _____

The Rensselaer Polytechnic Institute Student Health Center and its employees are hereby released from all legal responsibility or liability for the release of the records to the extent indicated and authorized herein. I understand that by sending information by facsimile it may be subject to viewing by unauthorized persons.

Signature of patient _____ Date _____
(or legal representative)

Witness _____ Date _____

Person releasing the information _____ Date _____

Information released by ☐ Mail ☐ Fax ☐ Copy to patient ☐ Phone ☐ Email

SHC rev 11/08

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