D'Youville

HEALTH RECORDS RELEASE

I hereby authorize release of information in my medical record

FROM: **D'Youville College Health Center**
505 Prospect Ave.
Buffalo, NY 14201
716-829-8777
716-829-7646 – fax

TO: _____
Name or Office

_____
Street

_____
City State Zip Code

_____
FAX Number or email address

ATTN: Medical Records:

Name: _____

Student ID (optional): _____

Birth date: _____

Signature **(REQUIRED)**: _____

Date of Request: _____

INFORMATION REQUESTED (Please be specific):

- ☐ Copy of Immunizations
- ☐ Copy of Physical
- ☐ Copy of Tuberculosis Test
- ☐ Copy of All Medical Records
- ☐ Review medical records/immunizations
- ☐ Other (please specify

_____

_____

****PLEASE ALLOW 24 TO 48 HOURS FOR RECORDS****