RELEASE OF MEDICAL INFORMATION

I, ____, Year of Graduation:______________________

____
(address)

hereby authorize Simpson College Health Services to release copies of medical and immunization records.

The following information may be released or reviewed:

- ( ) Immunization Records
- ( ) History and Physical Exam
- ( ) Other ____

The above information is to be released to:

____

____

____

Purpose For Disclosure: ____

REDISCLOSURE IS PROHIBITED WITHOUT SPECIFIC CONSENT OF THE PERSON TO WHOM IT PERTAINS.

This statement must be signed and dated and may be revoked at any time to the extent action has been taken prior to revocation. This consent will expire sixty (60) days after the date below, or sooner by choice, in which case this consent will expire on ________________________________.

______________________________________	______________________________________
Name	Signature
Address	Other person legally authorized to give consent
Relationship to patient and reason	
Today's Date	

This information is being disclosed to the above individual/organization for the above stated purpose from records whose confidentiality may be protected by Federal Law.