PHONE: 716.878.6711
FAX: 716.878.6727

CONSENT TO RELEASE MEDICAL INFORMATION

Patient Name: ____

(Please Print) Last First Middle

____

Maiden (if applicable)

Date of Birth: _________ /_________ / _________ **Banner ID:** ________________________

RELEASE RECORDS FROM: **Weigel Health Center**

Buffalo State College
1300 Elmwood Avenue
Buffalo, NY 14222

RELEASE INFORMATION TO:

Name or Office: ____

Street: ____

City: __________________________________ **State:** __________ **Zip:** ________________________

Phone Number: ________________________ **Fax Number:**__________________________________

MEDICAL INFORMATION TO BE SENT:

_____ Record of care from ________to ________
_____ Immunization Records
_____ Copy of last annual GYN, physical exam, pap smear, GC and Chlamydia tests
_____ Copy of any abnormal tests
_____ Summary of treatment for: ____
_____ Other (please specify): ____

I authorize medical information to be released as indicated above. I understand this release is effective for 60 days from the date of request. I also understand that signing this release is voluntary. I have the right to request restrictions or revoke the release of my medical information by writing to the Weigel Health Center.

Patient Signature: ______________________________________ **Date:** ____________________

First 10 pages for free. Each additional page 25 cents. Must have check or money order made out to Weigel Health Center before records will be release.