CONSENT TO RELEASE MEDICAL INFORMATION

Phone: Date of Birth:	Patient Name:					
Banner ID: Banner ID: Buffalo State College 1300 Elmwood Avenue Buffalo, NY 14222 BELEASE INFORMATION TO: Bame or Office: State: State: Fax Number: MEDICAL INFORMATION TO BE SENT: Record of care from Inmunization 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): authorize medical information to be released as indicated above. I understand this release is effective for 60 days is the date of request. I also understand that signing this release is voluntary. I have the right to request restrictions of evoke the release of my medical information by writing to the Weigel Health Center. Patient Signature: Date: The first 10 pages of each record are free. Each additional page is 25 cents. Only	Please Print)	Last First			Maiden (if applicable)	
Buffalo State College 1300 Elmwood Avenue Buffalo, NY 14222 BELEASE INFORMATION TO: Name or Office: State: State: Fax Number: Record of care from Immunization Records Copy of last annual GYN, physical exam, pap smear, GC and Chlamydia tests Summary of treatment for: Other (please specify): authorize medical information to be released as indicated above. I understand this release is effective for 60 days is the date of request. I also understand that signing this release is voluntary. I have the right to request restrictions of evoke the release of my medical information by writing to the Weigel Health Center. Patient Signature: Date: The first 10 pages of each record are free. Each additional page is 25 cents. Only	hone:					
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Center will be accepted. Payment must be received before records will be released.