Buffalo State
Weigel Health Center
PHONE: 716.878.6711
FAX: 716.878.6727

CONSENT TO RELEASE MEDICAL INFORMATION TO WEIGEL

Patient Name: _____
(Please Print) Last First Maiden (if applicable)

Phone: _____

Date of Birth: _____ /_____ / _____ **Banner ID:** _____

RELEASE INFORMATION FROM:

Name or Office: _____

Street: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Fax Number:**_____

RELEASE RECORDS TO:

Weigel Health Center
Buffalo State College
1300 Elmwood Avenue
Buffalo, NY 14222

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 pap smear, subsequent pap smears, colposcopy & biopsy records
_____ 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:** _____