Buffalo State
Weigel Health Center
PHONE: 716.878.6711
FAX: 716.878.6727

CONSENT TO RELEASE MEDICAL INFORMATION

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

Phone: _____

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:** _____

The first 10 pages of each record are free. Each additional page is 25 cents. Only personal checks (photo ID required) or money orders made out to Weigel Health Center will be accepted. Payment must be received before records will be released.