

SKIDMORE
HEALTH SERVICES
RELEASE OF INFORMATION

I hereby authorize the release of the following information:

- | | |
|--|--|
| <input type="checkbox"/> TB Testing | <input type="checkbox"/> X-ray Reports |
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> GYN Physical Exam (office note),
Pap smear, cultures/lab results | <input type="checkbox"/> Other _____ |

Information to be released:

To _____ From: _____

Name: Skidmore College Health Services

Address: 815 North Broadway
Saratoga Springs
New York 12866

Telephone: (518) 580-5550 Fax Number: (518) 580-5556

Information to be released:

To _____ From _____

Name: _____

Address: _____

City/State/Zip: _____

Telephone: _____ Fax Number: _____

Expiration Date: _____

This is a specific authorization, may not be extended for any other purpose, and is at the request of the individual named below.

Student Name (Please PRINT): _____

Student Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Student Birth date: _____ Graduates Class Year: _____

Verbal/Telephone Consent