1200 Academy Street • Kalamazoo, Michigan 49006 • USA
ph 269.337.7200 • fx 269.337.7440
www.kzoo.edu/healthsv

AUTHORIZATION TO SHARE MEDICAL INFORMATION

I authorize Kalamazoo College Student Health Center to (circle one)

Release **Acquire** my:

- ❑ Immunizations
- ❑ Billing/Financial/insurance information
- ❑ Pap and pelvic records
- ❑ Lab results
- ❑ Other ____

from/to
Name: ____

Address: ____

____

Telephone: ________________________ Fax: ________________________

I understand that my records are protected under confidentiality regulations and cannot be released or re-released without my written authorization unless required by law. I also understand that I may revoke this consent at any time, except to the extent that release has already occurred. This consent will expire at the end of 60 days.

Name:____

Signature:______________________________ Date: ________________________
(electronic signature NOT accepted)

Maiden Name:______________________________ Date of Birth:__________________

Last Year Attended:__________________________ Student ID:____________________

Phone: (______)______________________________

For office use only.
Completed by:________________________Date: __________________