SKIDMORE
COLLEGE

HEALTH SERVICES

RELEASE OF INFORMATION

I hereby authorize the release of the following information:

- ☐ TB Testing
- ☐ Immunizations
- ☐ GYN Physical Exam (office note), Pap smear, cultures/lab results
- ☐ X-ray Reports
- ☐ Lab Reports
- ☐ 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.

Legal Student Name (Please PRINT): _____

Preferred Student Name (Please PRINT): _____

Student Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Student Birth date: _____ Graduates Class Year: _____

☐ Verbal/Telephone Consent Given