YORK COLLEGE
of
THE CITY UNIVERSITY OF NEW YORK
HEALTH SERVICES CENTER

PERMISSION TO RELEASE IMMUNIZATION RECORDS

Date:_____

I hereby authorize _____ to release immunization and medical records concerning my (son) (daughter) (self) _____, to *York College Health Services Center*, which requires these records in treating or dealing with (him) (her) (me).

S.S.#:_____

D.O.B.#:_____

LAST DATE ATTENDED: _____

Signed:_____

Witness: _____