RELEASE OF MEDICAL INFORMATION

Kirkwood Community College Campus Health

I, _____ hereby authorize Kirkwood Community College to release copies of medical and immunization records.

Address _____

DOB _____ K # _____ Program _____

The following may be released or reviewed:

- ☐ Immunizations
- ☐ TB test and 2-step TB Tests
- ☐ Titres or blood tests documenting immunity to a disease
- ☐ Health Physical
- ☐ Other _____

The above information is to be released to:

_____

_____

_____

Purpose for Disclosure: _____

I understand that I am giving my written permission to have the above information released to the person / facility listed above. When requesting any further personal records from Campus Health a new Authorization Release Form will be required.

_____	_____
Print Name	Signature
_____	_____
Address	Other person legally authorized to give consent
_____	_____
Last Year Attended Kirkwood	Relationship to client and reason
_____	_____
Today's Date	Phone Number

This information is being disclosed to the above individual/organization for the above stated purpose from records whose confidentiality maybe protected by Federal Law.

I specifically authorized the release of data and information relating to: (check the appropriate box)

- ☐ Substance Abuse (alcohol / drug abuse)
- ☐ Mental Health (includes psychological testing)
- ☐ HIV-Related Information (AIDS related testing)

_____ _____

Signature or Other person leagally authorized to give consent — Date

* In order for the above information to be released, you must sign here and above. *