

**AUTHORIZATION FOR  
RELEASE OF INFORMATION**

**Kirkwood Community College  
Campus Health**

Name \_\_\_\_\_ DOB \_\_\_\_\_ KCC ID # \_\_\_\_\_  
Local Phone \_\_\_\_\_ Local Address \_\_\_\_\_

I, as signed below, authorize and request Kirkwood Community College to release to and/or secure from

\_\_\_\_\_  
Name of Person or Facility \_\_\_\_\_ Address \_\_\_\_\_

information from my medical records for care and treatment. The medical information to be released should include:

- Immunizations (childhood and adult)
- Titres or blood tests documenting immunity to a disease
- TB tests and 2-step TB tests
- Health Physical
- Nurses Campus Health Visit Notes
- Medical Reports
- Other \_\_\_\_\_

This information is being used for the purpose of: \_\_\_\_\_.

I understand that I am giving my written permission to have the above information released to the person / facility listed above. This release of information consent will expire 1 year from today. I understand that I may revoke this consent at any time by sending a written notice to Kirkwood Community College, c/o Campus Health 6301 Kirkwood Blvd. SW Cedar Rapids, IA 52406.

\_\_\_\_\_  
Student's signature or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

**SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR 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 of Student or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

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