AUTHORIZATION TO RELEASE IMMUNIZATION RECORDS

INSTRUCTIONS to student:

1. *Complete* ***ALL*** *portions of this form.*
2. *Reason for request of records: Verification of immunizations is required for College admission.*
3. *Please sign form and a QVCC representative will fax it to your physician's office.*

Patient's Name: ____
(last name) *(first name)* *(middle name)*

Date of Birth:____________________________ Previous Name(s): ___________________________

Parent/Guardian (if child under 18 years of age): ____

Address: ____

City: _____________________ State:________ ZIP Code: ___________________

Phone Number: _____________________

I request and authorize _______________________________ located in ______________________ to release and fax (or mail)
(physician's practice/name) *(town/state)*

my immunization records to Quinebaug Valley Community College (information is shown below). Requested information should be faxed as soon as possible.

RECEIVING AGENCY:
Quinebaug Valley Community College
Student Success Center
742 Upper Maple Street
Danielson, CT 06239
FAX: (860) 932-4306
Phone (860) 932-4020

This authorization expires 60 days after the date it is signed. A copy of this document is considered the same as the original.

I further understand that I may revoke this authorization at any time by notifying the releasing organization in writing, but if I do it will not have any effect on any actions that were taken before my revocation is received.

By signing this authorization, I acknowledge that I have read and understand this authorization. I understand that immunization records to be disclosed will be disclosed in accordance with this authorization.

I declare under the penalty of perjury that the foregoing is true and correct, and that I am authorized to sign this release on the patient's behalf.

____ ______________________________
(signature of patient or parent/legal guardian if younger than 18 years) *(relationship to patient)*

Signed on________________________________at ____________________________________
(month/day/year) *(city and state where signed)*