Manhattan College Health Services
4513 Manhattan College Pkwy
Riverdale, NY 10471
Phone: 718-862-7217, Fax: 718-862-7797
Email: health.services@manhattan.edu

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Revised 4/2020

I authorize Manhattan College Health Services to **Disclose** information contained in my medical record.
Requests will be completed within 7 days of receipt. The student's signature must be on each request.

Full Name: ____. Student ID: _______________ Date of Birth: __________

Maiden/Other Names (if different from above). ____

Phone: ____________________________________. Last Semester Attended: _________________________________

Address: ____. Apt/Suite. __________________

City: _______________________________________. State: ____________________. Zip Code _________________

Information to be Received

Check all that apply

Immunizations

History & Physical

TB testing

Lab Reports

Episodic Visit Report

Other: ____

Entire Medical Record

(for dates): ____________________________________

Check all that apply (multiple copies may require additional processing time):

I will pick up a copy of my medical records. Please call me when they are ready.

Please mail a copy of my medical records to my address listed above.

Other (please specify):

____

Please forward a copy of my medical records to:

____

Signature to Disclose Release of Medical Information

____ ____________________________

Signature Date