RELEASE OF MEDICAL INFORMATION

I, _____, Year of enrollment _____ or year of graduation:_____ here by authorize Simpson College Health Services to release copies of medical and immunization records.

The following information may be released or reviewed:

( ) Immunization Records

( ) History and Physical Exam

( ) Other _____

The above information may be released to:

( ) _____

( ) _____

( ) _____

Purpose for Disclosure: _____

DISCLOSURE IS PROHIBITED WITHOUT SPECIFIC CONSENT OF THE PERSON TO WHOM IT PERTAINS.

The statement must be signed and dated, and **remains in effect throughout the duration of the student's enrollment as a student at Simpson College and up to 5 years after graduation**, unless revoked by the individual at any time to the extent action has been taken prior to revocation.

_____

Printed Name Signature

_____

Address Other person legally authorized to give consent

_____

Today's Date

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