

Wesleyan University Davison Health Center
327 High Street
Middletown, CT 06459
(860) 685-2470
(860) 685-2471 Fax

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Student Name _____ Date of Birth _____

Wes ID# _____ Class Year _____ Phone # _____

Address _____

To: _____

From: Davison Health Center
327 High St.
Middletown, CT 06459

Fax: _____

To: Davison Health Center
327 High Street
Middletown, CT 06459

From: _____

Specific Information Desired:

Entire Record (may include alcohol/drug info,
HIV and mental health information)

Immunization records

All Laboratory Reports (including GYN)

Permission to discuss recent visits

Most Recent Laboratory Reports

Other _____

Information to be excluded from release (be as specific as possible including approximate dates treatment was provided):

I understand that I may revoke this authorization at any time but will not hold the Davison Health Center liable for the release of above stated information prior to revocation. This authorization will expire ninety (90) days from the date of my signature.

Signature _____ Date _____

Witness _____ Date _____