

## RECORDS RELEASE AUTHORIZATION

TO: DAVISON HEALTH CENTER – WESLEYAN UNIVERSITY

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

CLASS DEAN  \_\_\_\_\_

PROFESSOR  ALL OR SPECIFY \_\_\_\_\_

PARENT  ALL OR SPECIFY \_\_\_\_\_

GUARDIAN  ALL OR SPECIFY \_\_\_\_\_

OTHER  \_\_\_\_\_

THE DATE(S) OF MY VISIT(S) TO THE HEALTH CENTER

THE REASON FOR MY VISIT(S) TO THE HEALTH CENTER

DURATION OF ILLNESS OR SPECIFIC DATES \_\_\_\_\_

NAME \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_ WITNESS \_\_\_\_\_  
(If relative, state relationship)