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: _____

_____

_____

Fax: _____

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

❑ 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)

❑ All Laboratory Reports (including GYN)

❑ Most Recent Laboratory Reports

❑ Immunization records

❑ Permission to discuss recent visits

❑ 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 _____

5/09