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

RECORDS RELEASE AUTHORIZATION

I hereby authorize and request you to release to:

CLASS DEAN ❑ _____

PROFESSOR ❑ all or specify _____

PARENT ❑ 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 _____ Wes ID _____ Date _____

Signature _____ Witness _____

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