



**HEALTH SERVICES
RELEASE OF INFORMATION**

I hereby authorize the release of the following information (List specific information requested, i.e. lab reports, x-ray reports, etc.):

Copy of gyn physical exam (office note), Pap smear, cultures/lab results within 1 year.

Information to be released to:

Name: Skidmore College Health Services

Address: 815 North Broadway
Saratoga Springs
New York 12866

Telephone: (518) 580-5550 Fax Number: (518) 580-5556

Information to be released from:

Name: _____

Address: _____

City/State/Zip: _____

Telephone: _____ Fax Number: _____

Expiration Date: _____

This is a specific authorization, may not be extended for any other purpose, and is at the request of the individual named below.

Student/Employee Name (Please **PRINT**): _____

Student/Employee Signature: _____ Date: _____

Witness Signature: _____ Date: _____