SKIDMORE
COLLEGE

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.):

Information to be released: ☐ To ☐ From:

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: ☐ To ☐ 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 Name (Please PRINT): _____

Student Signature: _____ Date: _____

Witness Signature: _____ Date: _____

releas.doc Rev. 02/03, 5/05