COLUMBUS STATE COMMUNITY COLLEGE
HEALTH RECORDS OFFICE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name: ____

Previous Names**: ____

Technology: ____

SS#/Cougar ID ____

Address: ____

____

**** Please include all names you used while a student at Columbus State.**

I hereby authorize Health Records Office to release information from my health record to (check one):

______ Myself

______ Name: ____________________________

Agency: ____________________________

Address: ____________________________

____

FAX #: ____________________________

I request that the following information be released (check all that apply):

______ TB Test Results

______ Immunization Records

______ Laboratory Test Results

______ Physical Examination Records

______ Other (please specify below)

____

This release expires on __________________ or in 60 days, whichever comes first.

Signature: ____ Date: __________

Witness: ____ Date: __________

Copy/USPS/Faxed/Emailed By: __________________________ Date: __________

ID Verification Completed: __________
(Please Initial)

Please allow approximately 5 business days for processing