

**YORK COLLEGE**  
*of*  
**THE CITY UNIVERSITY OF NEW YORK**  
**HEALTH SERVICES CENTER**

PERMISSION TO RELEASE IMMUNIZATION RECORDS

Date: \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to release  
immunization and medical records concerning my (son) (daughter) (self)  
\_\_\_\_\_, to *York College Health Services Center*,  
which requires these records in treating or dealing with (him) (her) (me).

S.S.#: \_\_\_\_\_

D.O.B.#: \_\_\_\_\_

LAST DATE ATTENDED: \_\_\_\_\_

Signed: \_\_\_\_\_

Witness: \_\_\_\_\_