University of Massachusetts Lowell
Student Health Services
71 Wilder St, Suite 5
Lowell, Massachusetts 01854-3091

Tel: 978-934-4991
Fax: 978-934-3080

Authorization for Release of Immunization Records

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

Student ID/SS#: _____

I hereby authorize: _____
(name of institution/health care provider)

_____
(address)

_____
(phone/fax)

To release my immunization record.

University of Massachusetts Lowell
Student Health Services
71 Wilder St, Suite 5
Lowell, Massachusetts 01854-3091

Tel: 978-934-4991 Fax: 978-934-3080

This authorization will expire in six (6) months from the date signed and may be revoked at any time in writing prior to the expiration date not to be retroactive to the original release date. I release the facility and its employees from any liability or legal responsibility that may arise from this authorization.

_____ _____
(signature of patient or legal guardian) (date) (signature of witness)