DORDT
STUDENT HEALTH AND
COUNSELING CENTER

Authorization for Release of Immunization Record

(*This release will ONLY be used for release of Immunization Records.)
Please fax this completed form to Student Health & Counseling at (712) 722-6991). This form can also be mailed to address below or emailed to health@dordt.edu

Student Identification:
Name:_____
Student Phone #:_____ Date of birth:_____
Email:_____
Last Semester (e.g. Fall 2013):_____

Provider Releasing Records:

Dordt University Student Health & Counseling
700 7th Street NE
Sioux Center, IA 51250
Ph: (712) 722-6990 Fax: (712)722-6991

Release Records To: (Person or Place records should be sent to)
Name:_____
Phone:_____ Fax:_____

Information Requested:
_____ Immunization Record

Purpose of Release:
_____ Medical Care _____ At the request of the patient
_____ Other, please explain:_____

Time Limit: I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition_____

Signature of Student/ Legal Representative:_____
Date: _____