Randolph-Macon College
Ashland, Virginia

POB 5005
Ashland, Virginia 23005
Phone:804-752-3041 Fax: 804-752-3776

# AUTHORIZATION TO RELEASE IMMUNIZATION RECORDS

Patient's Name: ______________________________ Date of Birth: ____________________

Previous Name: ______________________________ R-MC Graduation Year: ____________________

I authorize the Randolph-Macon Health Center to release my Immunization Records to my current address:

Name: ____________________________________________________

Address: __________________________________________________

City: ____________________ State: __________ Zip Code: ____________________

If you transferred in or out of R-MC, please indicate the year you transferred AND your expected year of graduation.

Transfer Year: __________ Expected Graduation Year: ________________

Please include a phone number in the event we need to contact you about your records: ____________________

Patient Signature: ______________________________ Date Signed: ______________