RANDOLPH-MACON
COLLEGE
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 the following address or secure fax.

Fax: _____

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: _____