Student Health Services – Room A402
Fashion Institute of Technology
Phone (212) 217-7625 Fax (212) 217-8253

Medical Release Form

Please Print

Date: ___________________________

I, ____, hereby request the release of my F.I.T.

medical records to ____,
(name of practitioner and title)

Practitioner's address: ____
City / State / Zip: ____
Phone #: _________________________ Fax #: _______________________

Patient Signature: ____

Social Security No.: __________________________ Birthdate: _______________________

Date of graduation from F.I.T.: ____

Date of withdrawal from F.I.T.: ____

Check one:

- ❑ Records related to today's visit only
- ❑ My medical information only
- ❑ Complete records
- ❑ Other _______________________________
- ❑ Lab tests only
- ❑ Gyn only
- ❑ Pap(s) only

Please note: If this form is not filled out in person at the F.I.T. Health Service, it must be NOTARIZED. **Medical Release forms NOT notarized will not be processed**.

CONFIDENTIALITY STATEMENT

The information contained is privileged and confidential; intended for use of the individual or entity named above. If the reader of this form is not the intended or the employee or agent responsible to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited.