

**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)

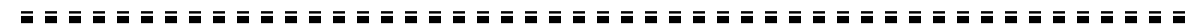
Practitioner's address: \_\_\_\_\_  
City / State / Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Social Security No.: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Date of graduation from F.I.T.: \_\_\_\_\_

Date of withdrawal from F.I.T.: \_\_\_\_\_



**Check one:**

- |  |   |
|--|---|
| <input type="checkbox"/> Records related to today's visit only | <input type="checkbox"/> Lab tests only |
| <input type="checkbox"/> My medical information only           | <input type="checkbox"/> Gyn only       |
| <input type="checkbox"/> Complete records                      | <input type="checkbox"/> Pap(s) only    |
| <input type="checkbox"/> Other _____                           |   |

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.