Farmingdale State College
State University of New York

Release of Information

Release to: ☐ **Self (Given)** ☐ **Self (Mailed)** ☐ **Other (Mailed)** **Date** _____ / _____ / _____

Name: _____ **RAM ID #: R** _____ -_____ -_____
Last First Middle

Address: _____
Number Street Apt

_____
Town State Zip Code Country

I hereby authorize and request the Health and Wellness Center at Farmingdale State College to release to the above specified person(s) the following confidential medical information regarding my health:

_____

_____

_____

_____

_____

_____

_____

_____

I understand that the medical information being released is strictly confidential and is for professional use only.

Name: _____
Last First Middle

Date of Birth _____ **RAM ID #: R** _____ -_____ -_____

Signature _____ **Witness** _____

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