



Manhattan University Health Services
4513 Manhattan College Pkwy Riverdale,
NY 10471
Phone: 718-862-7217, Fax: 718-862-7797
Email: health.services@manhattan.edu

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Revised 07/2026

I authorize Manhattan University Health Services to **Disclose** information contained in my medical record.
Requests will be completed within 7 days of receipt. The student's signature must be on each request.

Full Name: _____ Student ID: _____ Date of Birth: _____

Maiden/Other Names (if different from above). _____

Phone: _____ Last Semester Attended: _____

Address: _____ Apt/Suite. _____

City: _____ State: _____ Zip Code _____

Information to be Received

Check all that apply

Immunizations

History & Physical

TB testing

Lab Reports

Episodic Visit Report

Other: _____

Entire Medical Record

(for dates): _____

Check all that apply (multiple copies may require additional processing time):

I will pick up a copy of my medical records. Please call me when they are ready.

Please mail a copy of my medical records to my address listed above.

Other (please specify):

Please forward a copy of my medical records to:

Signature to Disclose Release of Medical Information

Signature

Date