Health Records Request Form

Date:_____

I_____hereby authorize the Medical Records Office at

_____to release my immunization records
***(Name of College or University*)** **(including meningitis information if available)**

To: **St. Bonaventure University**
Office of Graduate Admissions
Box 2520
St. Bonaventure NY 14778
Fax: 716-375-4015
Email: gradsch@sbu.edu

Student Information

Student Name: _____

Maiden or Former Names (if any) _____

Social Security Number_____ Date of Birth_____

Student Address: _____
Street

_____
City **State** **Zip Code**

_____
Home Phone **Cell Phone**

_____
Email

Dates of Attendance: From_____ To_____
(mm/yr) ***(mm/yr)***

Student's Signature_____

Witness Signature (if required)_____

This permission expires 60 days from date of request.