



Powerful Futures Start Here

Office of the Registrar - Cape Cod Community College -
Student Immunization Records 2240 Iyannough Road, West Barnstable, MA 02668
774-330-4331 • Fax: 508-375-4039 • immunizations@capecod.edu

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Your health information is confidential and protected by state and federal laws. The information you submit is maintained by Cape Cod Community College Student Immunization Records Office in the strictest confidence. HIPAA regulations prevent us from releasing or discussing any health information without written consent of the patient, except when there is imminent danger to you or to others, or when required by law.

Last Name: First Name: Student ID #:

Other Name(s) (if different from above): Date of Birth: (mm/dd/yyyy)

SSN: Phone: Dates of Attendance: (mm/dd/yyyy)

Address: City: State: Zip:

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Permission is hereby given for Cape Cod Community College Student Immunization Records Office to release the information specified below from the medical record to:

Telephone Fax

I understand that the information to be released may include information protected by federal and state laws. By my signature below, I authorize the disclosure and/or discussion of the following checked information:

- Complete Health Record Immunization Record Physical Exam Laboratory Report(s)

METHOD OF RELEASE AUTHORIZED: (Check all that apply)

- Permission to fax Student/Authorized 3rd Party picks up information in person
- Information sent by mail Verbal / Telephone

THIS AUTHORIZATION IS VALID FOR THE DURATION OF THE ABOVE NAMED STUDENT'S ENROLLMENT AT CAPE COD COMMUNITY COLLEGE FROM THE DATE OF SIGNATURE. THIS AUTHORIZATION WILL BECOME NULL AND VOID UPON THE STUDENT'S SEPARATION FROM THE COLLEGE.

I understand that I may revoke this consent in writing at any time, except to the extent that action has already been taken in response to this authorization. I also release the Cape Cod Community College Student Immunization Records Office from any liability or legal responsibility in connection with the release of the above information.

Student Signature: _____ Date _____

For Student Immunization Records Office Use:
Date Completed: _____ # of Pages Copied: _____ Staff Initials: _____