LIU Brooklyn

University Health & Medical Services
UHMS
Keeping you well, so you can excel!

175 Willoughby Street,
Brooklyn, NY 11201
718-246-6450- Office

We are committed to protecting the confidentiality of student information. To this end, we must obtain your written authorization before we may distribute/disclose your information—this form provides that authorization and must be submitted with a clear, valid picture identification card.

Doctor's Office/ Institution to **receive/send** (*circle one*) information:
_____
_____
_____
ATTN: _____

Fax #:_____
Telephone#:_____
# of Pages: _____
Facility #: ***718-246-6450***
to confirm receipt of fax

AUTHORIZATION FOR RELEASE OF IMMUNIZATION/CLINICAL RECORDS:

Name of Student: _____

Date of Birth: _____ Age: _____

Social Security Number: _____ or SID#: _____

I _____, (*print name*) authorize the release of any and /or all my information regarding my immunization record:

For the purpose of: Follow-up Patient Care ❑ New School ❑ Insurance Issues ❑ Work ❑
Other ❑ (please specify) _____

In an effort to support student needs, UHMS will only fax a copy of our MMR/MEN Form as proof of immunization to a valid doctor's office and/or another institution of higher learning.

Special requests for additional information to be distributed: _____
_____

_____ _____
Signature: Date:

_____ _____
Signature (if a minor, parent or guardian) Date:

Fax approved for urgent documents **only** to: **718-246-6465** **Other:** _____

Original MMR/MEN Forms must be mailed/received for final clearance by UHMS.
Please note all documents with a doctor's signature/stamp must be in its original format and all approved fax copies must be clear and legible.

UHMS USE ONLY: *Staff Processing Request:*_____
Date Received: _____ *Date Processed:* _____ *ID Attached:*_____
Comments: _____