

## Release of Information

Release to	o: □ Self (Given)	☐ Self (Mailed)	☐ Other (Ma	iled)	Date	_//
Name:	Last	First		Middle	RAM ID #: R	
Address:	Number		Street	Apt		
_						
	Town			State	Zip Code	e Country
	uthorize and request the following confide				ate College to release to t	he above specified
I understa	and that the medical i	nformation being rel	eased is strictly	y confidential a	nd is for professional use	only.
Name:	Last		First			Middle
Date of Ri	irth				RAM ID #· R	
Date of Di					π.	<del></del>
Signature				Witness		

