**PASADENA CITY COLLEGE**
**Student Health Services**
**1570 E. Colorado Blvd.**
**Pasadena, California 91106**
**(626) 585-7244**

## AUTHORIZATION TO RELEASE INFORMATION

Patient's Name: _____ DOB: _____ Last 8 digits of PCC ID: _____
Last First MI

I authorize Pasadena City College, Student Health Services to forward to:

_____
Patient's Name or Name of Institution

_____
Address

_____
City State Zip Code

_____
Fax Number

the following medical record(s):

____ Immunization records

____ Copy of lab results (please specify): _____

____ All medical records

____ Other: _____

_____ Date: _____
Patient's Signature

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***Office Use Only***

Identification:

Type: _____ ID #: _____ Exp. Date: _____

Type: _____ ID #: _____ Exp. Date: _____

Verified By: _____ Date: _____