UNIVERSITY OF RIO GRANDE
AND RIO GRANDE COMMUNITY COLLEGE

Health Services Medical Release Form

I _____ give my permission to have my medical/shot records from the University of Rio Grande/Rio Grande Community College released to:

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

The medical/shot records should be sent by: ☐ Mail ☐ Fax ☐ Pickup

Signature of Student _____ Date _____

Thank you,

Amy L. Weaver
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Student Services
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