

THE UNIVERSITY OF MAINE AT MACHIAS
Health Center
116 O' Brien Ave., Machias, ME 04654
Tel. (207) 255-1275 Fax (207) 255-1474

IMMUNIZATION RELEASE FORM

Date _____

I hereby request and authorize release of my immunization records from The University of Maine at Machias.

PLEASE PRINT

Please forward them to: _____

Name/Organization

Address

City, State, Zip Code

(____) _____ (____) _____
Fax Number Phone Number

Student Name Date of Birth

Address

City, State, Zip Code

Signature