



IMMUNIZATION RELEASE FORM

Date _____

I hereby request and authorize release of my immunization records from: (PLEASE PRINT)

Name/Organization

Address

City, State, Zip Code

**TO: The University of Maine at Machias, Health Center
116 O'Brien Ave., Machias, ME 04654
Tel. (207) 255-1275 Fax (207) 255-1474**

Student Name

Date of Birth

Signature