Western University OF HEALTH SCIENCES

100 W. Second Street, Room 219
Pomona, CA 91766-1700
Tel: (909) 706-3830 • Fax: (909) 706-3785

AUTHORIZATION FOR RELEASE OF STUDENT/EMPLOYEE HEALTH RECORDS

College: **COMP** **Dental** **Nursing** **Optometry** **Podiatry** **PT** **PharmD** **PA** **Vet Med** **MSMS**

Oregon Campus: **COMP** **OT** **PT**

Student / Employee ID # @ ___________________________ **Grad. Year: 20 _________**

Please Print

Name	DOB	Sex: Male Female
Address		Phone:
City/State/Zip		

I hereby request and authorize that the **Student-Employee Health Office** email my Health Clearance Records to my **WesternU email address** of:_________________________@westernu.edu

The Health Clearance Records I am authorizing for release include:

*Immunizations/Titers *Tuberculosis Clearance Documents *History and Physical Exam

Other:____

NOTE: Unless lined out, those with an * will be sent to the email address you indicate.

A handwritten signature is required in order to activate this request.

Student Signature____Date______________________

Note: A photocopy or electronic scan of this document shall be as valid as an original.
This Authorization is valid until otherwise notified in writing.

Revised 9/14; 5/17/10/20; 10/1/22