

Office of Medical  
Student Education

Department of Family and  
Community Medicine

Name: \_\_\_\_\_

Date: \_\_\_\_\_

UTHSCSA ID#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**AUTHORIZATION FOR DISCLOSURE OF IMMUNIZATION RECORD INFORMATION**

I, the undersigned, hereby waives the right to the privilege of confidentiality, and authorizes the UTHSCSA Student Health Clinic to provide access to my immunization record for the purpose of UTHSCSA Clerkship Program or rotational purposes. Please forward the information to the person(s) in the following department.

Jill Stetzer  
Name of person(s) to receive information

Family & Community Medicine, FAX: 567-2443  
Department

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date Signed by Student

**ANY DISCLOSURE OF IMMUNIZATION RECORD INFORMATION BY THE  
RECIPIENT(S) OF THE ABOVE RELEASED INFORMATION IS PROHIBITED.**