



Authorization for Release of Medical Information

As a Vanderbilt University student, I authorize Vanderbilt Student Health Center to share my immunization record with Vanderbilt Occupational Health Center. I understand that my records will be reviewed and additional vaccinations and/or medical health requirements may need to be met for employment at Vanderbilt University Medical Center.

Name: _____	Date of Birth _____
Vanderbilt Commodore ID <u>000</u> _____	
Student Email Address: _____ @vanderbilt.edu	
Student Signature: _____	Date: _____

Return this form to:

Dara L. Dixon, RN, BSN, Clinic Manager

Student Health Center

Vanderbilt University Medical Center

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