Office of the Registrar
350 Highland Ave
Nyack, NY 10960
Fax (845) 348-3918
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PERMISSION FOR RELEASE OF MEDICAL RECORDS

I._____PERMIT NYACK COLLEGE/ALLIANCE THEOLOGICAL SEMINARY TO RELEASE MY MEDICAL RECORDS TO:

NAME:_____

ADDRESS:_____

_____

_____

SIGNATURE:_____DATE:_____

BIRTHDATE:_____

SS #:_____

This form may be mailed or faxed to us. In addition it may be mailed to the person and address you indicate above or faxed if you include a fax number.