



NJCU HEATH & WELLNESS CENTER
VODRA HALL, SUITE 107
PH # 201-200-3457
FAX # 201-200-2011

Medical Record Release

I, the undersigned, hereby authorize New Jersey City University, Health and Wellness Center, to release a copy of the appropriate medical/immunization records requested below.

Information to be released (please check):

[] Immunization Record only

[] Entire Medical Record* (including Immunization Record)

* Please note that we only have medical records that you have provided to us and/or any record of treatment at the NJCU Health & Wellness Center.

[] Other (Please specify) _____

Name (Please print) _____

Address _____

City, State, Zip _____

NJCU Student ID # _____ or SS # _____

D.O.B. _____ Dates attended NJCU _____ Contact Ph # _____

Signature (Required) _____ Date _____

Witness _____

Kindly forward the above requested information to:

Name _____

Address _____

City, State, Zip _____

Fax #: _____

FOR OFFICE USE ONLY
INFO SENT: _____
PICKED UP _____
MAIL _____ FAX _____
DATE: _____
BY: _____

