NJCU HEALTH & WELLNESS CENTER - VODRA HALL, SUITE 107
2039 John F. Kennedy Blvd., Jersey City, NJ 07305
PH # 201-200-3456 - FAX # 201-200-2011 – EMAIL: HWC@NJCU.EDU

Medical Record Release

Name _____
(PLEASE PRINT) **FIRST NAME** **MIDDLE INITIAL** **LAST NAME**

Address _____
CITY **STATE** **ZIP**

NJCU Student ID # _____ **or** Last 4 digits of SS # XXX – XX - _____

D.O.B._____ Year attended NJCU _____ Contact Ph # _____
MO/ DAY/YEAR

A **TO OBTAIN COPIES OF YOUR RECORDS (IMMUNIZATION OR MEDICAL) FROM NEW JERSEY CITY UNIVERSITY:**	**B** **TO OBTAIN COPIES OF YOUR RECORDS (IMMUNIZATION OR MEDICAL) FROM ANOTHER PHYSICAN OR SCHOOL OUTSIDE OF NEW JERSEY CITY UNIVERSITY:**
☐ I hereby authorize **New Jersey City University, Health and Wellness Center,** to release a copy of the medical/immunization records requested below.	☐ I hereby authorize you to release to **New Jersey City University, Health and Wellness Center,** a copy of my medical and/or immunization records request below.
Information to be released (please check): ☐ **Immunization Record only** ☐ Entire Medical Record* ☐ Other (Please specify) _____ ** Please note that we only have medical records that you have provided to us and/or any record of treatment at NJCU Health & Wellness Center.*	***Information to be released*** (please check): ☐ **Immunization Record only** ☐ Entire Medical Record ☐ Other (Please specify) _____
Please send my records to: Name: _____ Address: _____ _____ ☐ Fax #_____ ☐ Email:_____ ☐ Copy taken in-person by student	**Please send my records to:** **NJCU HEALTH & WELLNESS CENTER** VODRA HALL, SUITE 107 2039 Kennedy Blvd., Jersey City, NJ 07305 **FAX # 201-200-2011** **EMAIL: HWC@NJCU.EDU**

Signature *(Required)* _____ Date _____
MO/ DAY/YEAR

Witness _____

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