

Caldwell College Health Services
11 Ryerson Avenue, Caldwell, NJ 07006
Fax 973-618-3540
Authorization for Release of Health Form/Medical Records

I, _____,
(name printed)

Authorize the release of my:

- _____ immunization records only
- _____ complete health form
- _____ other please explain _____

I am authorizing the released records to be:

- _____ mailed to _____
(name)

(street address)

(city, state, zip)
- _____ faxed to _____
(name)

(facility)

(fax number)
- _____ I will pick them up

(name printed)

(signature)

(date of birth)

(today's date)

(date of last semester at Caldwell College)

(Caldwell College ID#, if known)

Release of any of the following information will require a separate release form:

- **Mental Health Records**
- **Sexual Assault Records**
- **Drug/Alcohol Treatment**
- **AIDS/HIV Testing**