Caldwell University Health Services
120 Bloomfield 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 University) **(Caldwell University ID#, if known)**

Cell Phone Number _____

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**

Email completed form to: SHS@caldwell.edu
Please note that during July and August processing of submitted forms may be delayed.