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**