

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)

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