RUTGERS
New Jersey Medical School

Student Health Services
Rutgers Health Sciences Campus at Newark
Rutgers, The State University of New Jersey
90 Bergen Street, Suite 1750
Newark, NJ 07103

www.njms.rutgers.edu/shs

p. 973.972.8219
f. 973.972.0018

Authorization for Release of Information

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY AND ATTACH A GOVERNMENT ISSUED IDENTIFICATION COPY.

1. I hereby request and authorize Student Health Services to release information from the health record(s) of:

Patient's Name	**Patient's Date of Birth**
Patient's School/Program and Class	

2. The requested information is to be sent to (name of doctor, hospital, person or organization where records should be sent):

Name:
Address/Fax/Rutgers Email:

Delivery Preference (select one):

☐ Pickup
☐ Mail
☐ Electronically (if released to active student)
☐ Fax

3. Please specify the information to be released (please check off below):
   - Copies of my health information within the following dates: _____ to _____

☐ Immunization Records
☐ Varicella Titer
☐ HepB Titers
☐ TB Skin Tests
☐ Chest X-ray reports (if applicable)
☐ Physical Examinations
☐ Bloodborne Pathogen Exposure
☐ Lab tests
☐ Full copy of medical records
☐ Other (please specify): _____

4. Purpose/reason for release of records (please check off):

☐ Medicare
☐ Insurance
☐ Legal Matter(s)
☐ Marketing
☐ Fundraising
☐ School
☐ Clinical rotation
☐ Residency
☐ Other (please specify)

5. I have attached a copy of my personal identification (government issued driver's license or identification number, passport) with this request.

☐ Yes
☐ No

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- I understand the nature of the authorization and that this authorization can be revoked at any time by the person giving authorization, with a written and dated notice, except to the extent that disclosure made in good faith has already been made prior to receipt of the revocation.
- I understand that my treatment is not conditioned on obtaining this authorization.
- I understand that this authorization is specific for release only to the above party and expires (30) days following the date of signature.
- I understand it may take up to thirty (30) days for records to be processed and released.
- I understand that information used or disclosed may no longer be protected by the federal privacy laws.
- I understand that I can be charged a fee for obtaining copies of my records. Please call for any questions around fees.
- If the requested information involves mental health information, I acknowledge that I am aware that New Jersey has a statutory privilege accorded to confidential communications between a patient and a licensed psychologist and that release of such information may waive this privilege.

_____ _____

Printed Name of Patient | Signature of Patient

_____ _____

Printed Name of Patient's Representative | Signature of Patient's Representative

_____ _____

Date | Relationship to the Patient