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

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 Graduation Year	
Cell Phone Number:	

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

Name:
Address/Fax/ Email:

Delivery Preference (select one):

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

3. Please specify the information to be released (please check off below):
   - o 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
     - ☐ Blood borne Pathogen Exposure
     - ☐ Lab tests
     - ☐ Full copy of medical records
     - ☐ Other (please specify): _____
4. Purpose/reason for release of records (please check off):
   - ☐ Medicaid
   - ☐ 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

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

- 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