STOCKTON UNIVERSITY
101 Vera King Farris Drive | Galloway, NJ 08205-9441
stockton.edu

The Wellness Center
Division of Student Affairs

Health Services | WQ108
P: 609.652.4701 • F: 609.626.5586
Counseling Services | J204
P: 609.652.4722 • F: 609.626.5550
Learning Access Program | J204
P: 609.652.4988 • F:609.626.5550
Women's, Gender & Sexuality Center | J204
P: 609.626.3611 • F:609.626.5550

Authorization to Release/Obtain Health Records

Instructions:

1. Complete this entire form to release/obtain medical records. If you are requesting medical records an AtlantiCare Release form must also be submitted.
2. Attach a photo ID
3. Please allow two-weeks for the Office of Health Services to process your request.

I hereby authorize the disclosure of immunizations from the Office of Health Services:

Student's First Name	Student's Last Name	Former or Maiden Name

Phone Number (with area code)	Student's Z#	Date of Birth

Health Information to disclose:

❑ Immunizations ❑ Medical Records

Method of disclosure:

❑ Release my Medical Records from Stockton's Office of Health Services to:

Name: _____

Address: _____

Fax No.: _____

❑ Release my Medical Records to Stockton Office of Health Services from:

Name: _____

Address: _____

Fax No.: _____

I understand that this information will be released in accordance with HIPAA and FERPA laws as applied and will begin on the date signed. This information can be revoked at any time except to the extent that action on the disclosure was already taken in reliance on it. If not previously revoked, this consent will terminate one year from the date of signing or on _____(mm/dd/yyyy)

_____ _____
Student's Signature Date

_____
Parent/Guardian's Signature if student is under 18

Official Use Only File with record when completed

Completed by: _____ Date completed: _____ Delivery method: ❑Faxed ❑Mailed ❑In Person

Updated 02/2015 lad
R: shared doc/forms/medical release form