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

Student Health and Wellness
Division of Student Affairs

Counseling and Psychological Services
P: 609.652.4722 • F: 609.626.5550
Student Health Services
P: 609.652.4701 • F: 609.626.5586
Learning Access Program
P: 609.652.4988 • F:609.626.5550
Health Outreach, Promotion, and Education
P: 609.652.4701 • F: 609.626.5586

Office of Health Services: Authorization to Release/Obtain Records

Instructions:

1. Complete this entire form to release/obtain records.
2. Attach a photo ID

Please allow two-weeks for the office of Health Services to process your request.

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

Student's Name: _____ Former or Maiden Name: _____

Phone Number: _____ Student's Z# _____ Date of Birth: _____

Information to disclose:

- ❑ Immunizations
- ❑ Tuberculosis Screening
- ❑ Medical Records
- ❑ Athletic Physicals, Indicate Year(s) _____
- ❑ Other: _____

Method of disclosure:

- ❑ Release my records from Stockton's Office of Health Services to:
  Name: _____
  Address: _____
  Fax No.: _____
- ❑ Release my 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