Medical Record Release

Name_____
(PLEASE PRINT) FIRST NAME MIDDLE INITIAL LAST NAME

Address _____
CITY STATE ZIP

NJCU Student ID #_____ or Last 4 digits of SS #XXX¿I–ñ wGQR0E*HD^mŒ§ã HS

☐ I hereby authorize New Jersey City University, Health and Wellness Center to release a copy of the medical/immunization records requested below.	ANOTHER PHYSICAN OR SCHOOL OUTSIDE OF NEW JERSEY CITY UNIVERSITY ☐ I hereby authorize you to release to New Jersey City University, Health and Wellness Center a copy _____ ☐ ☐ ☐