NJCU HEALTH & WELLNESS CENTER, VODRA HALL, SUITE 107
2039 John F. Kennedy Blvd., Jersey City, NJ 07305
PH # 201-200-3456 - FAX # 201-200-2011 t EMAIL: HWC@NJCU.EDU

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-XX-ñ wGQR0E*HD^mŒ§ã HS

A

☐ I hereby authorize New Jersey City University, Health and Wellness Center, to release a copy of the medical/immunization records requested below.

B

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

_____

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☐

☐

VODRA HALL, SUITE 107
2039 Kennedy Blvd., Jersey City, NJ 07305
FAX # 201-200-2011
EMAIL: HWC@NJCU.EDU

Signature (Required) _____ Date _____
MO/ DAY/YEAR

Witness _____

Revised Fall 2016