




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 EMAIL: HWC@NJCU.ED

Medical Record Release

Name \_\_\_\_\_  
 (PLEASE PRINT FIRST NAME MIDDLE INITIAL LAST NAME)

Address \_\_\_\_\_  
 CITY STATE ZIP

NJCU Student ID # \_\_\_\_\_ or Last 4 digits of SSN \_\_\_\_\_

  <input type="checkbox"/> I hereby authorize New Jersey City University, Health and Wellness Center to release a copy of the medical/immunization records requested below	<p><b>B</b></p> <p><b>ANOTHER PHYSICIAN OR SCHOOL OUTSIDE OF NEW JERSEY CITY UNIVERSITY</b></p> <input type="checkbox"/> I hereby authorize you to release to New Jersey City University, Health and Wellness Center a copy
---	---

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

Signature (Required) \_\_\_\_\_ Date \_\_\_\_\_  
 MO/ DAY/YEAR

Witness \_\_\_\_\_