Saint Peter's UNIVERSITY

Department of Health Services

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: ______________________________ Date of Birth: ______________

ID#: ______________________________ Telephone: ______________

Address: ______________________________

Release From: (Name of Facility of Clinician Releasing Information):

I authorize release of my medical records from:

Facility/Name of Physician: ______ Saint Peter's University ______ Other ______

(Specify) ______________________________

Address (If different from Saint Peter's University

facility): ______________________________

Release To (Name of Facility/Clinician/Person Receiving Information):

Name: ______________________________

Complete Address: ______________________________

Telephone # ______________ Fax# ______________

Release Information:

Reason: _____Moving out of area _____Requirement for school _____Personal file

Please Release the Following (check all that apply):

______Immunizations

______Laboratory Results Only (specify) ______________________

______Other Information (specify) ______________________

Consent:

This information is intended by the above named recipient only. I have a right to receive a copy of this authorization. I may revoke this authorization at any time in writing.

Signature of Patient: ______________________________ Date: ______________

Witnessed By: ______________________________ Date: ______________

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The Jesuit University of New Jersey