COLLEGE of SAINT ELIZABETH

AUTHORIZATION TO RELEASE MEDICAL AND IMMUNIZATION RECORDS TO THE COLLEGE OF SAINT ELIZABETH HEALTH SERVICES

Date _____

Student Name _____

Date of Birth _____/____/_____

Address _____

City _____ **State** _____ **ZIP Code** _____

Phone Number _____-_____-_____ **Student ID** _____

I request and authorize (High School, College, Healthcare Provider, School Nurse)

_____

to release (check all those that are indicated)

☐ **Immunization Records** □ **Medical Records**

to Health Services at the College of Saint Elizabeth. Please forward my records to:

College of Saint Elizabeth
Health Services – Founders Hall
2 Convent Road
Morristown, NJ 07960
Attention: Priya Shrestha, Coordinator, Medical Records

If you wish, you may fax the information to (973) 290-4182.
Questions/Concerns please call (973) 290-4132 or 4175.

Signature _____ **Date** _____

Name of Parent or Guardian (if under 18) _____
Please print

Signature of parent or guardian (If under 18) _____

Relationship to patient _____