REQUEST FORM TO OBTAIN IMMUNIZATION or MEDICAL DOCUMENTS FROM HEALTHCARE PROVIDERS, SCHOOL NURSES, PREVIOUS SCHOOLS/COLLEGES/UNIVERSITIES

To: High School, College, Healthcare Provider, school Nurse
(please print name/address of provider)

_____

_____

From: Name of Student / Date of Birth

_____

Date: _____

Re: Request and Authorization for the Release of: (check all those that are indicated)

☐ Immunization Records ☐ Medical Records

I hereby grant permission for the release of my immunization records and/or medical records to Health Services at the College of St. Elizabeth. Please forward my records to:

College of St. Elizabeth
Health Services – Founders Hall
2 Convent Road
Morristown, NJ 07960
Attention: Madeline Cook, Coordinator, Medical Records

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

Student's Name (Print) _____

Address _____

Telephone Number _____ Date of Birth _____

Signature _____ Date _____