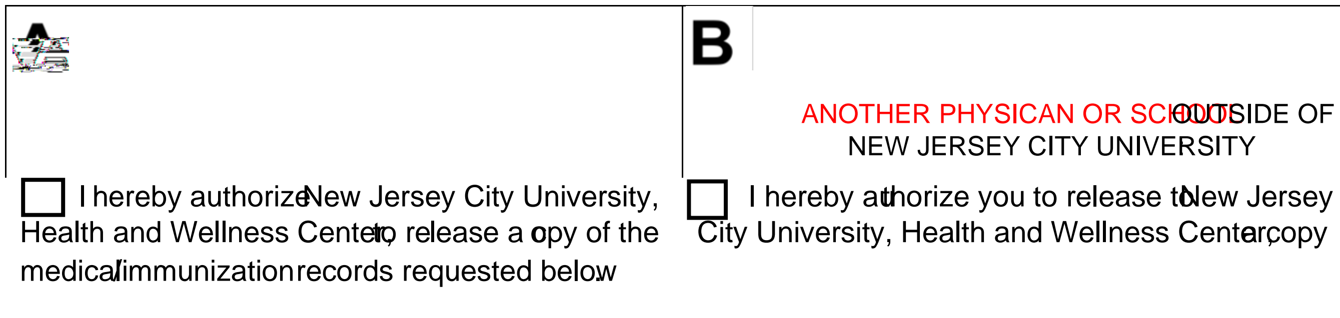
NJCU HEALTH & WELLNESS CENTER – VODRA HALL, SUITE 107
2039 John F. Kennedy Blvd., Jersey City, NJ 07305
PH # 201-200-3456 - FAX # 201-200-2011 t EMAIL: HWC@NJCU.ED

Medical Record Release

Name ____
(PLEASE PRINT) FIRST NAME MIDDLE INITIAL LAST NAME

Address ____
CITY STATE ZIP

NJCU Student ID # ____________________ or Last 4 digits of SS # XXX¿I–ñ wGQR0E*HD^mŒ§ã HS



A	B
	ANOTHER PHYSICAN OR SCHOOL OUTSIDE OF NEW JERSEY CITY UNIVERSITY
☐ I hereby authorize New Jersey City University, Health and Wellness Center, to release a copy of the medical/immunization records requested below.	☐ I hereby authorize you to release to New Jersey City University, Health and Wellness Center, a copy

	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