


THE
RICHARD STOCKTON COLLEGE
OF NEW JERSEY

P.O. Box 195 Jim Leeds Road Pomona, New Jersey 08240-0195
Health Services WQ-108
Phone (609) 652-4701 • Fax (609) 626-5586

**DIVISION OF STUDENT AFFAIRS
OFFICE OF COUNSELING AND HEALTH SERVICES**

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize The Richard Stockton College of New Jersey to release the health information of:

Student's Name _____ Date of Birth _____

Student I.D. or SS# _____ Telephone # _____

Student's address _____

Did you Graduate from Stockton? No Yes, Year _____ Fall Spring Summer

Records to be Released to: Student as identified above
**Immunization records will be released to the student only.*

Medical Provider *(Please fill out information below)*
Name _____
Address _____
Phone # _____ Fax # _____

Health Services Office policy states that any student requesting copies of medical records for their personal use must complete this form. This form may be obtained in person or by mail. At the time of request, **proof of identification must be presented.** Records will be released in person or by mail (**No records will be faxed**). If a medical provider is requesting a student's records for immediate treatment, the records may be faxed to the provider once the provider has supplied proof of identity.

Information is to be released from records pertaining to:

- | | | |
|---|--------------------------------------|---|
| <input type="checkbox"/> Complete Medical Record
<i>(Does not include Immunizations)</i> | <input type="checkbox"/> Laboratory | <input type="checkbox"/> *Immunization Record |
| <input type="checkbox"/> Nutritionist Record ONLY | <input type="checkbox"/> Radiology | <input type="checkbox"/> Athletic Physical |
| | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Free-To-Be Physical |

Information is to be released for the purpose of: _____

For Dates of Service: _____

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable state and federal regulations. I understand that I have the right to revoke this authorization at any time prior to The Richard Stockton College of New Jersey's compliance with the request. The revocation must be in writing and is subject to terms described in The Richard Stockton College of New Jersey's Notice of Privacy Practices and other Richard Stockton College policies.

I understand that I am not required to sign this authorization and that The Richard Stockton College of New Jersey may not condition treatment or services on my execution of this authorization.

I understand that the information disclosed by this authorization may be redisclosed by the recipient and will no longer be protected by HIPAA.

This authorization will expire upon the release of the information described above or 6 months (180 days) after the date of the authorization, unless specified otherwise. Expiration date: _____

Signature of patient or personal representative

Date

Personal representative's relationship to patient _____

Patient is entitled to a copy of signed authorization.