**Authorization to Release/Obtain Health Records**

**Instructions:**
1. Complete this entire form to release/obtain medical records. If you are requesting medical records an AtlantiCare Release form must also be submitted.
2. Attach a photo ID
3. Please allow two-weeks for the Office of Health Services to process your request.

I hereby authorize the disclosure of immunizations from the Office of Health Services:

<table>
<thead>
<tr>
<th>Student’s First Name</th>
<th>Student’s Last Name</th>
<th>Former or Maiden Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone Number (with area code)</th>
<th>Student’s Z#</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

Health Information to disclose:
- [ ] Immunizations
- [ ] Medical Records

**Method of disclosure:**
- [ ] Release my Medical Records from Stockton’s Office of Health Services to:
  - Name: ____________________________
  - Address: ____________________________
  - Fax No.: ____________________________

- [ ] Release my Medical Records to Stockton Office of Health Services from:
  - Name: ____________________________
  - Address: ____________________________
  - Fax No.: ____________________________

I understand that this information will be released in accordance with HIPAA and FERPA laws as applied and will begin on the date signed. This information can be revoked at any time except to the extent that action on the disclosure was already taken in reliance on it. If not previously revoked, this consent will terminate one year from the date of signing or on ___________________ (m/dd/yyyy)

___________________________  __________________________
Student’s Signature          Date

___________________________  __________________________
Parent/Guardian’s Signature if student is under 18

**Official Use Only**

Completed by: __________________  Date completed: _____________  Delivery method: [ ] Faxed  [ ] Mailed  [ ] In Person

Updated 02/2015 lad
R: shared doc/forms/medical release form