Monmouth University
Health Services
400 Cedar Avenue
West Long Branch, NJ 07764
Phone: 732-571-3464
FAX: 732-263-5353

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize release of the following medical information by Monmouth University Health Services: Check all that apply:

- ☐ Immunization Record
- ☐ Student Health Record/Employee Health Record
  - ☐ History and Physical
  - ☐ Treatment/Progress Notes
    - ☐ All
    - ☐ Notes between _____(date) to _____(date)
- ☐ Lab/Diagnostic Tests specify: _____

Purpose of record release: ☐ Transfer of records to an educational institution ☐ Employment
☐ Transfer of records to a private physician ☐ Legal
☐ Other: specify:_____

The following require individual authorization: Sign and check all that apply

- ☐ Mental Health _____ Signature Date
- ☐ Sexual Assault/Victimization _____ Signature Date
- ☐ Drug/Alcohol Treatment _____ Signature Date
- ☐ HIV status _____ Signature Date

Records are to be: (please choose one)

- ☐ Mailed-- Address where records are to be mailed:_____
  _____
- ☐ Picked up by student/employee. If other, please specify:_____
- ☐ Faxed. Fax number of authorized area:_____

Notice to Receiving Entities: The information disclosed to you is from records protected by State and Federal law. Entities receiving this information are prohibited from further disclosure without written consent of the patient.

This authorization is valid for 90 days from the date of the signature. Authorization may be revoked for any item at any time by written request.

_____ _____
Signature Date of Request

_____ _____
Print Name Address

_____ _____
Date of Birth Phone Number

_____
Student ID Number (students only)

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Office use only: What was released *By Whom:*

_____ *Health Record* *Date* _____ _____
_____*Immunization Record* *Date* _____ _____
_____*Lab/Diagnostic Tests* *Date* _____ _____
_____*Other* *Date* _____ _____