Authorization to Release Medical and Immunization Records to Saint Elizabeth University Health Services

Saint Elizabeth University
MORRISTOWN, NJ

Date _____

Student Name _____

Date of Birth _____ / _____ / _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ - _____ - _____

I request and authorize (High School, University, Healthcare Provider, School Nurse)

_____

to release (check all those that are indicated)

❑ Immunization Records ❑ Medical Records

to Health Services at Saint Elizabeth University. Please forward my records to:

Saint Elizabeth University
Health Services – Founders Hall
2 Convent Road
Morristown, NJ 07960
Attention: Priya Shrestha, Coordinator, Medical Records

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

Signature/Date _____

Name of Parent or Guardian (if under 18) _____

Signature of Parent or Guardian (if under 18) _____

Relationship to patient _____