

SETON HALL UNIVERSITY
HEALTH SERVICES
TEL: 973-761-9175 FAX: 973-761-9193

RELEASE OF MEDICAL INFORMATION

Your medical information may be released only with your written permission or by court order. Please indicate below which information is to be released and the manner in which it is to be obtained.

Patient Name _____ SHU ID# _____

Maiden name _____ Telephone # _____ D.O.B _____

Date graduated or date last attended SHU _____ Today's Date _____

Material or Communication Requested:

- Immunization Records
- Laboratory Results
- Confirmation of office visit on _____
- Email Professor (s) _____
- Communicate with my parents/guardians
- Communicate with Associate V.P. & Dean of Students
- Communicate with Athletics Department
- Other: _____

The following information requires your specific initials and will be released only if it is signed:

HIV testing _____ *Substance abuse referrals* _____ *Mental health referrals* _____
STD testing _____ *Sexual assault* _____

Send To:

- Self _____
- Other _____
- Fax Records/Fax Number _____ Attention _____
- Mail Records/Mailing Address _____
- I will pick up these records on this date _____

I authorize the release of these records as indicated and certify that I am the patient stated above. I understand that there may be sensitive information within these records regarding my health.

Signature _____ Initials _____ Date _____

Processed by _____ Date _____