THE LEADER IN GLOBAL EDUCATION

FAIRLEIGH DICKINSON UNIVERSITY

STUDENT HEALTH SERVICES
Metropolitan Campus
1000 River Road, T-SU2-03
Teaneck, New Jersey, 07666
Phone: (201) 692-2437
Fax: (201) 692-2642

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Name: _____
Last First FDU Student ID#

Date of Birth: _____/_____/_____ ☐ **Current Student** **First Semester at FDU:** _____
Month Day Year ☐ **Former Student** **Last Semester at FDU:** _____

I request and authorize Student Health Services:

CHOOSE ONLY ONE ☐ To Send/Disclose to ☐ To Receive From
Fees Apply

Name:_____

Address: _____

_____

Phone Number: _____ Fax Number: _____

THE FOLLOWING INFORMATION:

☐ Immunization Records ☐ Physical Exam ☐ Radiology/Xray ☐ Laboratory ☐ Other (Specify): _____

I understand that I should make and keep a copy of these records for future use, as the Health center will not keep my records beyond 10 years.

I hereby release Fairleigh Dickinson University Student Health Services from all legal responsibility or liability that may arise from the act I have authorized above.

_____ _____
Student's Signature Date

_____
Telephone Number

Please sign the above authorization and return it to Fairleigh Dickinson University Student Health Services. Information will not be released until this properly signed authorization has been received. If you have any questions concerning this authorization, please call the Student Health Center.

FOR OFFICE USE ONLY

Request fulfilled on: _____ by _____
Date Staff Initials

☐ Picked Up ☐ Mailed ☐ Faxed Payment Received: (Date) _____