

HEALTH OFFICE

- FX Nurses: 973-389-2035 / 973-389-4225 / 973-389-4145 - Fax #: 973-389-4125
- FX Nurses: 973-790-6000 Ext. 5018 - Fax #: 973-389-4125
- Main Lobby Nurses: 973-389-7218 / 973-389-4226 - Fax #: 973-790-6670
- Rocco Nurse: 973-389-4169 - Fax #: 973-389-4146
- STEM Nurses: 973-585-2235 / 973-790-6000 Ext. 5019 - Fax #: 973-646-3542 / 973-646-3533

MEDICAL RECORDS RELEASE AUTHORIZATION

I, _____ hereby give permission to
Name of Student / Parent or Guardian re:

_____ to release from my files the following information:
(Name of Person making the Disclosure)

(Extent or Nature of Information to be Disclosed)

This information is to be release to _____

(Name of Person/Agency onto which the Disclosure is to be made)

The purpose or need for such disclosure is: _____

This information may be given _____
(Indicate Frequency)

This consent is subject to revocation at any time except to the extent that action has been taken in
reliance therein and will otherwise expire on: _____
(Date, Event, or Condition)

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (HIPAA/FERPA) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

Signature of Student – Parent/Guardian To Give Consent DATE

Signature of Witness – RN/CSN DATE