



CONSENT FOR THE RELEASE OF MEDICAL INFORMATION

Instructions: The patient (student) must complete this form in its entirety in order for Ramapo College, Center for Health & Counseling Services, Office of Student Health Services, to release any medical information. The patient (student) must be specific as to the nature of the information he/she would like released and the purpose for which it is requested.

I authorize Ramapo College, Center for Health & Counseling Services, Office of Student Health Services to release my medical information as described below {*check appropriate box(s)*}

- General medical clinic notes and labs**
- Well Women's Clinic (gynecology clinic) notes and labs**
- Men's Health Clinic**

accumulated during the period beginning _____ and ending _____
mo/day/year mo/day/year

to _____
(Name of Individual)

(Address)

_____ for the purpose of _____.
(Telephone Number)

The information is for use only by the person named above and may not be disclosed to any other individual or agency without the patient's (student's) consent or as otherwise provided by law.

This authorization is subject to revocation at any time by the patient. (student)

Patient's Signature _____ DOB: _____

Printed Name: _____ ID #: R _____

Legal Address _____

Telephone # _____

Date: _____

This authorization will expire in one (1) year unless requested to expire at an earlier date.



Center for Health & Counseling Services

Student Health Services

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