



Authorization for Release of Medical Information

I understand that the information released cannot be disclosed by the person or institution named unless I specifically authorize such release in writing.

Name: _____

(PLEASE PRINT CLEARLY)

Date of Birth: _____

Telephone: _____

I, _____ hereby authorize John Jay College of Criminal Justice to release my medical information to:

Name: _____

Address: _____

Fax #: _____

The following information from my medical records:

_____ **Immunization Record** _____ **Other**

For the purpose of: _____ **School requirements for registration** _____ **Other**

Please: _____ **Mail** _____ **Fax** _____ **Pick up**

Signature of Student: _____ **Date:** _____

ALONG WITH THIS DOCUMENT PLEASE SUBMIT COPY OF PHOTO IDENTIFICATION AND \$5 MONEY ORDER MADE OUT TO:

John Jay Health Services

524 West 59th Street, Room L67.01NB

New York, New York 10019

Telephone: 212-237-8052/3

healthoffice@jjay.cuny.edu