Kean Wellness Center Student Health Services
1000 Morris Ave. Union, NJ 07083 | Downs Hall, Room 126
Tel: (908) 737-4880 | Fax: (908) 737-4888
Email: studenthealthservices@kean.edu

Authorization to Release/Exchange Confidential Information

This form cannot be used for the re-release of confidential information provided to Kean University Student Health Services by other individuals or agencies. Such requests should be referred to the original individual or agency.

I ,_____, Kean ID#_____, authorize Kean University Student Health
PRINT NAME
Services to use and disclose my health information as described below.

Current phone number: _____ Current email address: _____

A. Check any that apply:

I authorize: the release of information to ___ obtain information from ___ verbally exchange information with ___

- ❑ Kean University Student Health Services (Contact information can be found at the heading of this form.)
- ❑ Individual name or organization: _____
  Telephone: _____ Fax: _____
  Address:_____City:_____ State:_____Zip:_____
- ❑ Kean University Counseling Center
- ❑ Kean University Athletics
- ❑ Other (specify): _____

B. Information pertaining to:

Dates of Service: From:_____ **To:** _____ Or **Office Visit Date (specify):** _____

Information Requested: (check any that apply):

- ❑ Immunization Records*
- ❑ TB (Tuberculosis) test records*
- ❑ Record of Office visits and progress notes
- ❑ Diagnostic test results (Labs, x-rays & other test results)
- ❑ Gynecology Records
- ❑ Information contained in the medical record for verbal exchange with above mentioned party for coordination and collaboration for treatment efforts
- ❑ Other (specify): _____

*Immunization and TB results may be available on the Pyramed Student Health Portal and can be accessed without this request for students who entered Kean after May 2018. To access log onto kean.studenthealthportal.com, go to My Profile, Immun. History and print PDF.

I consent to have Kean University Student Health Services receive or send my health care information by telephone, fax or mail. I understand that:

- This authorization is voluntary. I may revoke/withdraw this Authorization in writing at any time, except to the extent that action has been taken prior to receipt of the revocation/withdrawal.
- Once my health information is disclosed as requested, it may no longer be protected by federal and state privacy laws and could be re-disclosed by the person(s) receiving it.
- The medical information may contain information related to **HIV status, sexually transmitted diseases and sexual health, behavioral and mental health and drug & alcohol use, etc.**

Signature of Student: _____ Date: _____

If under the age of 18, parent/guardian name: Print: _____ Signature: _____

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