

Request for the Release of

MEDICAL RECORDS FORM

For the Following Student: (Please Print)

NAME: _____

ADDRESS: _____

PHONE #: _____

SOC. SEC. #: _____

I hereby grant permission to the following medical personnel to release my medical records **as it pertains to my disability**. These records should include all narrative evaluations of diagnosis, tests that were administered to obtain diagnostic results, and any and all medications as it pertains to the diagnosis, etc.

Name of Physician _____

Office Phone Number _____

Office Address _____

Student Signature _____

Date _____

Please forward documentation to:

Administrator, Office of Special Services

Gloucester County College

1400 Tanyard Road

Sewell, NJ 08080

This form is to be completed in its entirety by the student. Please provide your personal information at the top, as well as the appropriate medical office information requested. This form is then to be signed and forwarded, by the student, to the medical personnel. ****Note: If you are able to obtain the medical records pertaining to your disability directly from the physician/medical personnel, please bring these records to the Office of Special Services. You do NOT need to submit this 'Medical Release' form.****