## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS & INFORMATION

		Student V #		Date of Birth
Address				
	Street	City	State	Zip Code
hereby authorize the release of	of medical information (ch	neck one):		
To/ UCU Student Heal	Ith Services	To/ Nar	me	
From: P.O. Box 842022,	Richmond, VA 23284-20	22 From:		
Phone: 804-828-8	3828 Fax: 804-828-109	3 Stre	eet	
☐ MCV Campus Stu	dent Health Services	City	, State, zip	
P.O. Box 980201			·	
Richmond, VA 232	298-0201	Pho	one	Fax
Phone: 804-828-9	9220 Fax: 804-828-318	1		
Specific Information Needed:				
Annual Gyn Exam & Pa	p Report Lab	Results Medi	cal Notes/Summary	X-Ray Report
Complete Record	Immunization Rec	ords Other: (p	olease specify)	
Purpose for This Disclosure: (0	Optional)			
Continuing Medical Tre	eatment Insu	ranceCons	ultation	Attorney
ther: (please specify)				•
I UNDERSTAND that I hav records are given to insura released to us will not be for	ince companies, attorneys urther transferred from this	s, or any other authorized s facility. I UNDERSTAND	persons, charges will this information may	be assessed. Information be faxed, hand carried, or mailed,
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University Student Health Services • 1300 W. Broad St., Suite 2200 • P.O. Box 842022 • Richmond, VA 23284 P: (804) 827-8047 • F: (804) 828-1093 • students.vcu.edu/health • Revised 7/2015