AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS & INFORMATION

Name _____ Student V # _____ Date of Birth _____

Address _____
Street City State Zip Code

I hereby authorize the release of medical information (check one):

To/ From:

☐ VCU Student Health Services
P.O. Box 842022, Richmond, VA 23284-2022
Phone: 804-828-8828 Fax: 804-828-1093

☐ MCV Campus Student Health Services
P.O. Box 980201
Richmond, VA 23298-0201
Phone: 804-828-9220 Fax: 804-828-3181

To/ From:

_____
Name

_____
Street

_____
City, State, zip

_____
Phone Fax

Specific Information Needed:

_____ Annual Gyn Exam & Pap Report _____ Lab Results _____ Medical Notes/Summary _____ X-Ray Report
_____ Complete Record _____ Immunization Records _____ Other: (please specify) _____

Purpose for This Disclosure: (Optional)

_____ Continuing Medical Treatment _____ Insurance _____ Consultation _____ Attorney
Other: (please specify) _____

I UNDERSTAND that I have the right to a copy of (for a fee) or to inspect the disclosed information if so requested. Whenever records are given to insurance companies, attorneys, or any other authorized persons, charges will be assessed. Information released to us will not be further transferred from this facility. I UNDERSTAND this information may be faxed, hand carried, or mailed, and persons other than those it is intended for may have access to it. I also understand that Student Health Services will attempt to keep records confidential. I HEREBY RELEASE THE ABOVE LISTED FACILITY, ITS EMPLOYEES, STAFF, AND AGENTS FROM ALL LEGAL RESPONSIBILITY OR LIABILITY THAT MAY ARISE FROM THE DISCLOSURE OF THE INFORMATION SET FORTH ABOVE RELATING TO MY MEDICAL RECORDS.

SIGNATURE: _____ DATE: _____
Patient or authorized person

ALCOHOL / DRUG / INFECTIOUS DISEASE / MENTAL HEALTH RECORDS are protected by Federal Regulation 42CFR, part 2. Release of such records requires specific consent. I hereby grant such specific consent. I UNDERSTAND that these records are protected under federal and state law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis prognosis, and treatment for physical and/or mental illness including treatment of alcohol or substance abuse, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection for any clinic visits.

SIGNATURE: _____ DATE: _____
Patient or authorized person

FOR STUDENT HEALTH SERVICES ONLY

Information to be: _____ Faxed _____ Mailed _____ Picked-Up _____ Other Date Needed: _____
Information sent by: _____ Date: _____
Fax Confirmation Attached: _____

VIRGINIA COMMONWEALTH UNIVERSITY
Division of Student Affairs | University Student Health Services

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

VCU is an EEO/AA institution.