AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL RECORDS OR 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 (USHS)
P.O. Box 842022, Richmond, VA 23284-2022
Phone: 804-828-8828 Fax: 804-828-1093

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

To/ From: ____
Name
____
Address
____
City, State, Zip
____
Phone Fax

Specific Information Needed:

☐ Annual Gyn Exam & Pap Report ☐ Lab Results ☐ X-Ray/Imaging Report ☐ Medical Notes/Summary ☐ Complete Record
☐ Immunization Records/Titers/TB Testing ☐ Other: (please specify) ____

Purpose for This Disclosure: (optional)

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

***As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health* records.** I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the medical records officer and is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity. This authorization expires in 12 months unless otherwise indicated. I may revoke this authorization at any time as relates to records or information not yet released by delivering my revocation in writing to USHS.

____ ___________________________

Signature of Individual *(or Individual's Legal Representative if Individual is Unable to Sign)* ***Date of Signature***

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Relationship or Authority of Legal Representative

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 of Patient or Authorized Person ***Date of Signature***

- This information has been disclosed to you from records that may be protected by federal confidentiality rules 42 CFR Part 2.
- The federal rules prohibit you from making any further disclosure of this information unless further discloser is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2.
- A general authorization for the release of medical or other information is not sufficient for this purpose.
- The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

FOR STUDENT HEALTH SERVICES ONLY

Information to be: ______ Faxed ______ Mailed ______ Picked-Up ______ Other
Date Needed: ______________________
Information sent by: ____ Date: _______________
Fax Confirmation Attached: ____________________