UNIVERSITY OF VIRGINIA
DEPARTMENT OF STUDENT HEALTH
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Office Use Only:
Processed by: _____Date_____
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CONSENT FOR THE RELEASE OF MEDICAL INFORMATION

Instructions: The patient must complete this form in its entirety in order for any healthcare facility to release medical information. The patient must be specific as to the nature of the information he/she would like released and the purpose for which it is requested. **Please print using black ink.**

I hereby authorize (*from*)_____
(Name of individual or agency releasing information)

_____
(Address)

to release my medical records as described below: *(check appropriate box(s))*

☐ General Medicine Clinic Notes & Labs ☐ Gynecology Clinic Notes & Labs
☐ CAPS Clinic Notes (Counseling and Psychological) ☐ SDAC Records
☐ Immunization Record ☐ Health Promotion Notes ☐ Other (must specify) _____

accumulated during the period beginning _____ and ending _____
(mo/day/year) (mo/day/year)

To_____
(Name of individual or agency)

_____
(Address)

Telephone# _____ for the purpose of _____
Fax#_____ *(Records cannot be emailed)*

This information is for use by the recipient named above only, and may not be disclosed to any other individual or agency without the patient's consent or as otherwise provided by law. This authorization is subject to revocation at any time except to the extent the healthcare facility has already taken action in reliance on it.
I understand that the information in my medical records may include information related to sexually transmitted disease, AIDS/HIV testing or diagnosis, mental health services, or drug/alcohol abuse diagnosis or treatment, and I consent to its release unless indicated in the following instructions: _____

I understand that Student Health will not withhold health care if I do not sign this consent, but that disclosure of private information to an outside entity such as a future employer or consulting physician will not be made without my consent. A copy of this consent and annotation concerning the persons or agencies to which disclosure was made will be included in my medical records. I understand that health information disclosed under this consent might be redisclosed by a recipient and no longer be protected by privacy laws.

I understand there is a handling fee not to exceed $10.00 and a fee of $.50 per page for pages 1-50, $.25 per page for pages 51+
Fees are waived when copies are requested for other health care provider's facilities/agencies for continuing of care.

Patient's Signature _____ Patient's Date of Birth _____

Printed Name _____ I.D.#_____

Address _____

Telephone Number _____ Email Address _____
Date: _____ This authorization will expire in one year. **Received by:** _____
SH Staff Signature

Revised Sept, 2016 JAM