University of Mary Washington
Student Health Center
1301 College Avenue
Fredericksburg, VA 22401
Phone (540) 654-1040 Fax (540) 654-1077

Authorization for Release of Medical Information

(Print Patient's full name) _____ Date of Birth (month/day/year) _____

(Dates of UMW Attendance) _____ Social Security # _____ (Phone) _____

Purpose for Disclosure

❑ Medical ❑ Personal ❑ Academic ❑ Legal ❑ Insurance/Billing ❑ Other (must specify)_____

Recipient/Custodian of Information

Person/agency/healthcare provider to whom information is to be released, or who is to release information to the Student Health Center:

Name_____

Complete Address_____

Phone_____(required) Fax_____

Choose ONE of the following options:

❑ I hereby authorize **The Student Health Center** to release the following information to the above named person/agency/healthcare provider.

❑ I hereby authorize **the above-named person/agency/healthcare provider** to release information to the Student Health Center.

❑ I hereby authorize the Student Health Center to exchange the following information with the above-named person/agency/healthcare provider.

Select the information to be shared:

- ❑ Immunization records only
- ❑ All information from this date forward: _____
- ❑ All information about my emergency room visit on _____
- ❑ All information about my hospital stay on _____

❑ All information	❑ Discharge summary	❑ History and physical
❑ Progress Notes	❑ Laboratory reports	❑ Radiology reports
❑ Operative Notes	❑ ECG	❑ Other_____

Modify the information released as below:

- ❑ I do ❑ I do NOT authorize the release of information related to:
- ❑ AIDS or HIV (Acquired Immunodeficiency Syndrome)
- ❑ Psychiatric care and /or psychological assessment
- ❑ Treatment for alcohol and/or drug abuse

I understand that I may cancel this request with written notification but it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person/agency/healthcare provider receiving it and would no longer be protected by federal regulations.

Signed: _____ **(Patient)** **Date:** _____

This authorization expires: _____
(month/day/year)