

**AUTHORIZATION FOR RELEASE OF INFORMATION**  
**(This is not a blanket release)**

Date \_\_\_\_\_

This is to certify that I, \_\_\_\_\_ G# \_\_\_\_\_,  
grant permission to George Mason University Student Health Services to:

- Release the information noted below from my medical records to:
  - medical provider \_\_\_\_\_
  - parents/ guardian \_\_\_\_\_
  - myself \_\_\_\_\_
  - other \_\_\_\_\_

Recipient: Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

**Information to be released:**

- All medical records to include all chart entries, diagnoses, test results, and reports
- All medical records except \_\_\_\_\_
- All records related to visits on the following dates \_\_\_\_\_
- All records related to the following diagnosis/symptoms \_\_\_\_\_
- Test results only

**Copy fee must be paid before records are released.**

Signed: \_\_\_\_\_

Witness: \_\_\_\_\_

**For Office Use Only**

Records have been reviewed by: \_\_\_\_\_ (initial ) \_\_\_\_\_(date)

\_\_\_\_ faxed # \_\_\_\_\_

\_\_\_\_ mailed

\_\_\_\_ picked up by patient

DATE: \_\_\_\_\_ BY: \_\_\_\_\_