

Request for Release of Medical Records to GMU

Patient's Name: _____

Student ID #: _____ Date of Birth: _____

I hereby authorize: _____
(name of health care professional or clinic)

(address)

(city, state, zip code)

_____ (phone number) _____ (fax number)

To Release:

_____ any/all lab work

_____ any/all records pertaining to my visit on _____
(date)

_____ all medical records

_____ other _____

To: George Mason University
Student Health Services
4400 University Drive, MS 2D3
Fairfax, VA 22030
Phone: (703) 993-2831
Fax: (703) 993-4365

(Patient's signature)

(Date)