GEORGE MASON UNIVERSITY | Student Health Services

# Request for Release of Medical Records to Mason

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:**

- ☐ Immunization records only
- ☐ All medical records
- ☐ Any/all records pertaining to my visit on _____ (Date)
- ☐ Other (please specify)

_____

**To:** *(check box below to select campus to send records to)*

☐ Fairfax Campus
Student Health Services
SUB 1, Room 2300
4400 University Drive, MS 2D3
Fairfax VA, 22030
Phone: (703) 993-2831
Fax: (703) 993-4365

☐ Science and Technology Campus
Student Health Services
Senator Colgan Hall, Room 229
10900 University Drive, MS 6D1
Manassas VA, 20110
Phone: (703) 993-8374
Fax: (703) 993-1948

☐ Arlington Campus
Student Health Services
Founders Hall, Suite B 102
3351 Fairfax Drive, MS 1H7
Arlington VA, 22201
Phone: (703) 993-4863
Fax: (703) 993-9425

_____ Date _____

Patient's signature/Parent or Legal Guardian

*Revised 9/16 eh*