GEORGE MASON UNIVERSITY | Student Health Services

RELEASE OF HEALTH RECORDS FROM MASON

Today's Date _____

Patient Name _____ Mason ID Number (G#) _____ Patient Date of Birth _____

Phone Number _____

WHO IS REQUESTING THE RECORDS RELEASE? (Choose PATIENT or AUTHORIZED REPRESENTATIVE)

Complete this section **ONLY if** an authorized representative is requesting the records release. This person must provide appropriate identification at the time this form is submitted.

Name of Authorized Representative	Relationship to Patient	Legal Authority

I grant permission for Mason Student Health Services to release the information noted below from my health records to:

RECIPIENT NAME _____

Address _____

City _____ State _____ Zip Code _____

SELECT RECIPIENT RELATIONSHIP TO PATIENT:

- ☐ Myself
- ☐ Medical provider
- ☐ Parent or guardian
- ☐ Other (please specify) _____

INDICATE INFORMATION TO BE RELEASED (select records below):

- ☐ Immunization Records ONLY **(no copy fee)**
- ☐ All Medical Records OR pertaining to the following dates/diagnosis (please specify) _____
- ☐ All Lab/Diagnostic Test Results OR pertaining to the following dates/diagnosis (please specify) _____
- ☐ Other (please specify) _____

Some records are not included unless specified. Select additional records for release:

- ☐ INCLUDE Outside records
- ☐ INCLUDE Genetic information
- ☐ INCLUDE Visits with the patient care advocate
- ☐ INCLUDE Substance misuse counseling

INDICATE THE REASON FOR RECORDS RELEASE: _____

HOW WOULD YOU LIKE THE RECIPIENT TO RECEIVE THE RECORDS? (select one option)

- ☐ Mail
- ☐ Fax to # _____ Must include a phone number for us to call to verify fax _____
- ☐ Pick up by patient. Bring a picture ID.
- ☐ Pick up by an authorized recipient (indicate recipient name): _____

  A picture ID MUST be provided. The name must match the recipient listed on this form.

Patient Name_____ Mason ID Number (G#) _____ Patient Date of Birth _____

COPY FEE MUST BE PAID BEFORE RECORDS ARE RELEASED.
Please be prepared to provide photo identification upon request.

- As the person signing this authorization, I understand that I am giving my permission to George Mason University Student Health Services (SHS) for disclosure of confidential health records.
- I understand that SHS may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization.
- I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to SHS (ATTN Privacy Officer) and will not apply to any actions already taken as a result of this authorization.
- A copy of this authorization shall be included with my original health records.
- I understand that health information disclosed under this authorization might be re-disclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of SHS.
- Student Health Services has up to 30 days to process this request.

NOTE TO RECEIVING FACILITY/PROVIDER:

This information has been disclosed to you from records which may be protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

SIGNATURE of Patient or Authorized Representative:_____ **Date of Signature** _____

EXPIRATION DATE is 1 (one) year from date signed, unless earlier date indicated: _____

SUBMISSION OPTIONS

Mail to: George Mason University, Student Health Services
4400 University Dr., MSN 2D3
Fairfax, VA 22030

for Questions Call: 703-993-2831

Drop Off: Student Union Building I (SUB I), Room 2300

Fax: 703-993-4365

FOR SHS OFFICE USE ONLY

FORM SUBMISSION
Authorized representative ID verified:_____ Verification of Authority_____

Date:_____ By:_____

RECORD REVIEW
Records have been reviewed by:_____ *(initial)* DATE:_____

☐ Access Denied ☐Access Partially Denied ☐ Letter sent: _____

RECORD DELIVERY
Fee Paid:_____

☐ Faxed #_____ ☐Fax # confirmed ☐ Mailed ☐Certified Mail

☐ Picked up by patient **OR** ☐Picked up by authorized recipient | ☐paper **OR** ☐electronic

ID verified:_____ DATE:_____ BY: _____