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:

☐ All medical records ☐ Any/all records pertaining to my visit on _____ (Date)

☐ Other (please specify) _____

For the purposes of: _____

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

I understand that I have a right to revoke this authorization at any time by providing written notice to Student Health Services. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

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

_____ _____
Patient's signature/ Parent or Legal Guardian Date

_____ _____
If other than patient, please PRINT Name and indicate relationship Relationship to patient