Student Health Services

FAIRFAX CAMPUS
SUB 1, Room 2300
4400 University Drive, MS 2D3
Fairfax VA, 22030
(703) 993-2831 · Fax: (703) 993-4365

SCIENCE AND TECHNOLOGY CAMPUS
Senator Colgan Hall, Room 229
10900 University Drive, MS 6D1
Manassas VA, 20110
(703) 993-8374 · Fax: (703) 993-1948

ARLINGTON CAMPUS
Founders Hall, Suite B 102
3351 Fairfax Drive, MS 1H7
Arlington VA, 22201
(703) 993-4863 · Fax: (703) 993-9425

AUTHORIZATION FOR RELEASE OF INFORMATION

(This is not a blanket release)

G# ______________________ Date ______________________

Date of Birth ______________ Phone Number ______________________

This is to certify that I, ______________________________ grant permission to Mason Student Health Services to

☐ Release the information noted below from my medical records to:

- ☐ Medical provider ________________________________
- ☐ Parents/guardian ________________________________
- ☐ Myself
- ☐ Other ____

Recipient:
Name ____
Address ____
____

☐ Fax to # __________________ ☐ Mail to Address above ☐ Pick up by Patient

Information to be released:

- ☐ **Immunization Records Only (no copy fee)**
- ☐ All medical records to include all chart entries, diagnoses, test results, and reports
- ☐ All medical records except: ☐ HIV/AIDS ☐ Mental Health ☐ Outside Records
- ☐ All records related to visits on the following date/diagnoses _______________________________________
- ☐ All records related to the following diagnosis/symptoms _______________________________________
____
- ☐ Test results only from the following date __________________________

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: ________________________________