University Life
STUDENT HEALTH SERVICES
George Mason University

# Request for Release of Medical Records TO George Mason University STUDENT HEALTH SERVICES

Patient's Chosen Name _____ Legal Name _____

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 by signing this authorization, my treatment, payment and enrollment in a health plan or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

I understand that the information disclosed may be subject to redisclosure by the person or entity receiving it and would then no longer be protected by federal privacy regulations.

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