724 S. Mason St., MSC 7901, Harrisonburg VA 22807
Email:healthctr@jmu.edu Telephone: 540-568-6249 Fax: 540-568-6176

CONSENT REQUEST FOR THE RELEASE OF HEALTH INFORMATION

INSTRUCTIONS: The patient must complete this form in its entirety in order for any health information records to be released **to** the University Health Center. Careful attention to the information provided when authorizing release of health information files is important. This information is for use by the recipient named only and is in accordance with the Family Education Rights and Privacy Act of 1974, a Federal law protecting the privacy of student education records.
This information cannot be given to any other individual or agency without the patient's consent.

DATE: _________________

STUDENT NAME: ____ **Student ID#:**____________________

CURRENT ADDRESS: ____

PHONE #: _____________________________ **BIRTHDATE:** ____________________________________

I authorize ____

Address:____

Phone:_____________________________________ FAX:____

To release my health information records, which consist of the following:
CHECK ALL THAT APPLY

__________ Immunizations, including immunization records from other providers

__________ GYN (Pap, Pelvic, Lab) _________________ (Date(s), as applicable)

__________ Lab ________________ (Date(s), as applicable)

__________ X-ray Results_______________(Date(s), as applicable)

__________ Other / Relating to Particular Problem, please specify: _________________________________

____

TO: James Madison University Health Center
Secure Fax: 540-568-6176
Mailing address: 724 S. Mason St., MSC 7901, Harrisonburg VA 22807

Signature:____