JAMES MADISON UNIVERSITY
HEALTH CENTER

MSC 7901
HARRISONBURG, VA 22807
www.jmu.edu/healthctr

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 from the University Health Center. Careful consideration of documentation and information should be realized in releasing health information files. This information is for use by the recipient named only. This is according to the Family Education Rights and Privacy Act of 1974 which is a Federal law that protects 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: ____

CURRENT ADDRESS: ____

PHONE #: ______________________ **BIRTHDATE:** ______________________

LAST YEAR ATTENDED JMU______________ **EMAIL**______________ **Student ID#:**____________
(OR last 4digits of SS#)

I authorize ________________________ to release my health information records, which consist of the following: (Name of Individual or Agency)

*****IMPORTANT – If you have left JMU prior to 2007, it could be 7 to 10 business days before your request is completed.**

CHECK ONE

__________ Immunizations, including immunization records from other providers

__________ Pre-Entrance Health Record to JMU

__________ Complete Health Information Chart, including records from other providers **($10.00 charge)**

__________ GYN (Pap, Pelvic, Lab) ________________ (Date(s), if any)

__________ Lab ________________ (Date(s), if any)

__________ Other / Relating to Particular Problem, please specify ________________________

__________ Verification of missed classes (For Professors/Employment) Date Called __________

to ____________________________________ ________________ ________________
(Name of individual or agency) (Telephone) (Fax)

____
Address

________________ ____
(Date) (Patient's Signature)

**** UHC can only fax Immunizations and the Pre-Entrance Health Record; all other requests will be mailed.**

Processed By: ______________________ Date: ____________ Pages: ______ Faxed _____
Mailed _____ Pick-up ______