

724 S. Mason St., MSC 7901, Harrisonburg VA 22807

[Email:healthctr@jmu.edu](mailto: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:**