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**CONSENT FOR THE RELEASE OF HEALTH INFORMATION**

INSTRUCTIONS: The patient must complete this form in its entirety in order for any health information to be released **from** the University Health Center. The released health information is for use by the named recipient 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.**

Released health information will be mailed or can be picked up in person. Labs or partial records can be faxed to another healthcare provider. All requests for the complete medical record will be mailed. The immunization record is the ONLY information that may be emailed via a non-secure email to the requesting party. The Health Center email is not a secure email. As such, any immunizations sent via email could be at risk for exposing health information.

Student Name: Student ID#

Current Address:

Telephone #: Birthdate:

I authorize the JMU Health Center to release the following health information: CHECK ALL THAT APPLY

 Immunizations, including immunization records from other providers Please send immunization record via: □ Email (not secure) □ Fax □ Mail

 Lab results (Date/s if any)

 Complete medical record, including record from other providers ($10 charge)

 Other/Relating to specific diagnosis or visit date, please specify

I authorize UHC to release my health information to

(Name of individual or agency)

(Address)

(Telephone) (Fax) (Email)

(Date) (Patient signature)

Processed By: Date: Pages: Faxed:

Mailed: Pick-up: Emailed:

Updated 01/25