University of Lynchburg

Health Services
RELEASE OF HEALTH INFORMATION

Student Name____ Date of Birth______________________

Phone____ ☐ Current Student ☐ Former Student

I hereby authorize the release of my medical information:

☐ To ☐ From University of Lynchburg Health Services
1501 Lakeside Drive, Lynchburg VA 24501
Ph: 434-544-8357 Fax: 434-544-8185
Email: healthservices@lynchburg.edu

☐ To ☐ From Name____

Address____

City/State/Zip____

Phone______________________________ Fax_____________________________

Email____

☐ Fax to number above ☐ Mail to address above ☐ Email to address above ☐ Patient pick up

Information to be released:

☐ Immunization/ TB testing records only
☐ All medical records, including all chart entries, diagnostics, test results and reports
☐ All records related to the following date(s) ________________
☐ All records related to the following diagnosis/symptoms __________________
☐ All records except: ☐ HIV/AIDS ☐ Psychiatric/Mental Health ☐ Drug/Alcohol Abuse ☐ STD testing
☐ Test results (specify date(s) ____________________
☐ Itemized bill (includes diagnosis and costs for service; specify dates) _________________

Purpose for information disclosure:

☐ Personal use ☐ Payment/Insurance ☐ Employment/Internship/Clinical ☐ Health care ☐ Other

This authorization will expire one year from the date it is signed unless otherwise indicated. I understand that this authorization is voluntary and that I can revoke this authorization at any time, except to the extent that information has already been released prior to receipt of the revocation. I understand that a revocation request must be made in writing to the University of Lynchburg Health Service. I understand that once information has been disclosed, redisclosure of the information by the recipient is possible and may no longer be protected by law.

Student Signature____ Date________________________

Office use: ☐ Faxed ☐ Mailed ☐ Emailed ☐ Patient pick up By: ____________ Date ___________