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**Reimbursement for Research Graduate Health and Recreation Center Fees  
and  
Consent for Release of Information Form**

Fees paid on behalf of a student are to be used in calculating federal financial aid award eligibility and, therefore, must be ascribed to a student's billing account. Fees paid on behalf of a student are disbursed to the student's account as a "scholarship". **Research Graduate** students, whose fees are funded by the Office of Graduate Studies and Research (OGSR), or funded by another institutional entity, are to have the fee recorded on their student account upon utilization of the facility.

The fee for use of the Student Health Center will be reimbursed only if a signed "Consent for Release of Information" form is placed on file at the Center for each semester in which a student uses the facility.



The College Of  
**WILLIAM & MARY**

Student Health Center  
PO Box 8795  
Williamsburg, VA 23187  
757/ 221-4386, Fax 757/ 221-1245

**CONSENT FOR RELEASE OF INFORMATION**

Name of patient (Printed) \_\_\_\_\_ DOB \_\_\_\_\_  
SSN or ID# \_\_\_\_\_ For previously enrolled students - last date  
attended W&M: \_\_\_\_\_  
Phone Number \_\_\_\_\_

**PURPOSE FOR DISCLOSURE**

- Medical     Personal     Academic     Legal     Insurance/Billing     Other (must specify): Research Grad Health Fee

**RECIPIENT/CUSTODIAN OF INFORMATION**

Person/agency/healthcare provider to whom information is to be released, or who is to release information to the Student Health Center:

Name Bursar, Financial Aid, Graduate Studies & Research, Individual Academic Dept./Program of Your Study

Address \_\_\_\_\_

Phone \_\_\_\_\_ (required)    Fax \_\_\_\_\_ (REQUIRED IF INFO IS TO BE  
FAXED OR A FEE WILL BE CHARGED)

**NOTE: Please check the box for ONE of the following options and describe the required information to be released**

**SEND THE FOLLOWING**

- I hereby authorize the Student Health Center to release the following information to the above named person/agency/healthcare provider:  
**Receipt for Health Fee**

**REQUEST THE FOLLOWING**

- I hereby authorize the above-named person/agency/healthcare provider to release the following information to the Student Health Center:

**EXCHANGE OF INFORMATION**

- I hereby authorize the Student Health Center to exchange the following information with the above-named person/agency/healthcare provider:

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As the person signing this consent, I understand that I am giving my permission to the above named third party for disclosure of confidential health records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and notation concerning the person or agencies to whom disclosure was made will be included with my original records.

\*\*\*I understand that the information to be released may contain information from other providers, confidential HIV/AIDS related information, confidential communicable disease information, information related to drug/alcohol abuse/treatment\*\* and/or psychiatric mental health information.

Signature of Student \_\_\_\_\_ Date \_\_\_\_\_

\*\*Consent expires 1 year after today's date unless another date is specified \_\_\_\_\_

**NOTICE TO RECIPIENT OF RECORDS:** The attached medical information is protected by federal privacy laws. You may not make further disclosures of the information without the consent of the student. In addition, you may use the information only for the purpose(s) for which the disclosure was made.

Health Center Staff Only: Date information sent \_\_\_\_\_ by \_\_\_\_\_