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):***_____

RECIPIENT/CUSTODIAN OF INFORMATION

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

Name_____

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 College of William and Mary Student Health Center to release the following information to the above named person/agency/healthcare provider (specify information to be sent) :**

REQUEST THE FOLLOWING

☐ **I hereby authorize the above-named person/agency/healthcare provider to release the following information to the College of William and Mary Student Health Center (specify information to be sent) :**

_____ _____

EXCHANGE OF INFORMATION

☐ **I hereby authorize the College of William and Mary Student Health Center to exchange the following information with the above-named person/agency/healthcare provider (specify information to be shared) :**

_____ _____

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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_____