

VIRGINIA TECH CHARLES W. SCHIFFERT HEALTH CENTER

McComas Hall 0140
Blacksburg, VA 24061

PHONE (540) 231-6608

FAX (540) 231-6900 or (540) 232-8687 or (540) 231-7473

**AUTHORIZATION FOR RELEASE OF INFORMATION
PER INCIDENT (This is not a blanket release)**

Date: _____

This is to certify that I, _____, ID # _____,
(Printed Name)

grant permission to _____ to release the information
noted below from my medical records to:

- ___ Medical provider _____
- ___ Parents/guardian _____
- ___ Myself _____
- ___ Other _____

Recipient: Name _____
 Address _____

Information to be released:

- ___ All medical records to include all chart entries, diagnoses, test results, and reports
- ___ All medical records except _____
- ___ All records related to visits on the following dates _____
- ___ All records related to the following diagnosis/symptoms _____
- _____
- ___ Immunization record (NO CHARGE)
- ___ **Itemized bill*** (includes diagnosis and itemized costs for service) _____
(Dates)
- ___ **Itemized bill Pharmacy*** _____
(Dates)
- ___ Progress notes and diagnoses only* _____
- ___ Test results only* _____
- ___ Consultant reports only* _____
- ___ Diagnosis only* _____
- ___ CD / Report

*** Specify the dates, notes, results, reports, and/or diagnoses to be released**

Signed: _____ Witness: _____

Office Use Only:

Information released: _____ Date: _____

Released to: _____ By: _____