

**VIRGINIA TECH CHARLES W. SCHIFFERT HEALTH CENTER**

McComas Hall 0140  
Blacksburg, VA 24061  
(540) 231-6608 FAX (540) 231-6900 or 231-7473

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

Date \_\_\_\_\_

This is to certify that I, \_\_\_\_\_, ID# \_\_\_\_\_,  
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 copy
- \_\_\_ 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\*

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

Signed: \_\_\_\_\_

Witness: \_\_\_\_\_

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**Office Use Only:**

Information released \_\_\_\_\_ Date: \_\_\_\_\_

Released to: \_\_\_\_\_ By: \_\_\_\_\_