VIRGINIA TECH CHARLES W. SCHIFFERT HEALTH CENTER

McComas Hall 0140
895 Washington Street SW
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)

DOB: ______________________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
($10.00 charge – check made payable to: Treasurer, Virginia Tech)

___ 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: ____________________