VIRGINIA TECH CHARLES W. SCHIFFERT HEALTH CENTER
McComas Hall 0140
Blacksburg, VA 24061
PHONE (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 (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* _____

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

Signed:_____Witness:_____

Office Use Only:
Information released: _____Date:_____

Released to:_____ By:_____