CONSENT REQUEST FOR THE RELEASE OF HEALTH INFORMATION

I hereby request the Wilkins Wellness Center provide me with a copy of my health information that is maintained by the Wilkins Wellness Center. Specifically I would like to:

[ ] Obtain a copy of my immunization record

[ ] Obtain a copy of by health record

[ ] Please mail a copy to the following address written below

[ ] Please scan and e-mail a copy to the email address written below

[ ] Please fax a copy to the following fax number written below

Name of individual or organization receiving the information:

_____

Address _____

Phone Number _____ Fax Number _____

Email **address** _____

I hereby authorize the Wilkins Wellness Center to release my health information to the above individual or organization:

Date: _____

Student's Name _____ **Date of Birth** _____

Student's Signature _____ **SU ID #** _____
(or last 4 digits of SS#)

Wilkins Wellness Center
1460 University Drive
Winchester, VA 22601
Phone (540) 665-4530
Fax (540) 665-5576

Date sent/received _____ Person providing Information _____