



3957 Pender Drive Suite 100, Fairfax, VA 22023
Phone: 703-591-1844 Fax: 703-591-7042

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Student's Name: _____ Date of Birth: _____
_____ Student's ID #: _____

I request and authorize Virginia International University to
release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information

Other: _____

Student's
Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES THIRTY DAYS AFTER IT IS SIGNED.