MEDICAL INFORMATION RELEASE FORM

I, _____, authorize
Print Name

Lynchburg College Student Health Services
1501 Lakeside Drive
Lynchburg, VA 24501
PHONE: 434-544-8357 FAX: 434-544-8185
EMAIL: healthservices@lynchburg.edu

_____ to receive information from
OR
_____ to release information to

Name _____

Address _____

_____

Phone _____ Fax _____
Email

☐ PHYSICAL EXAM ☐ IMMUNIZATIONS/PPD ☐ GYN EXAM REPORTS

☐ LAB TEST RESULTS (Specify)_____

☐ MEDICAL RECORDS RELATED TO _____

DATE: From _____ To_____

☐ OTHER _____

I understand that this authorization is subject to revocation at any time, except to the extent that the individual or entity that is to make the disclosure has already taken action in reliance upon it.

I also understand and agree that this authorization will terminate only upon the execution of my written statement indicating my intent to revoke this authorization and that without such written revocation; this authorization shall remain in full force and effect as specified in the expiration timeframe.

_____ _____ _____
Signature of Student S.S. # Date of Birth

_____ _____
Signature of Witness Date