Authorization To Release Copies of Medical Records
The George Washington University Student Health Center

University Student Center, Ground Floor
800 21st Street, NW | Washington, DC 20052
P: 202-994-5300 | F: 202-242-9922
Healthcenter.gwu.edu

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

Submit this request to Immunreq@gwu.edu
Submit payment at https://my.gwu.edu/mod/cse Reference ID#_____

- Immunization Record $5 (submitted Immunization Record in compliance with DC Law)
- Medical Records $15
- Medical Records Third party request $30

**Please allow up to 14 business days to complete record requests for medical and immunization records

Student/Patient Information
Name: _____
Date of Birth: _____(MM/DD/YYYY)
GWID: _____

I request and authorize the George Washington University Student Health Center to provide copies of my medical records, as outlined below, to the following entity/individual:

Name of Entity/Individual: _____
Address: _____
Phone: _____
Email: _____
Fax: _____

Scope of Authorization to Release Medical Records[1]:
☐Immunization Records ☐PPD/TB Skin Test Results ☐All Medical Records
☐Medical Records related to following visits: _____

PLEASE NOTE: if any record outlined above contains information regarding the student/patient's HIV/AID status, drug/alcohol abuse, or sexually transmitted disease, the student/patient is hereby authorizing disclosure of this information.

Purpose of Disclosure:
☐ To the Patient/Student ☐ For transition/continuity of health ☐ For payment/Insurance purposes
☐ For legal purposes ☐ Other: _____

Mode of Delivery (Select One):
☐Hold for Pickup ☐Email: _____ ☐Fax: _____
☐Mail to: _____

By signing below, I acknowledge and understand that:

- I am authorizing the University to release a copy of my medical records as outlined above.
- After the University Student Health Center discloses these records, the copies may no longer be protected by federal or local privacy laws.
- I have a right to inspect and receive a copy of the disclosed material.
- This authorization will expire upon fulfillment of this disclosure or earlier upon receipt of my written revocation to Immunreq@gwu.edu. I understand that revocation will not apply to information that has already been released in response to this authorization.
- This form is voluntary and I have the right to refuse to sign it. My treatment, payment, or eligibility of benefits will not be conditioned upon my authorization of this disclosure.

I represent and warrant that I have the authority to sign this document and authorize the disclosure of these records and that there are no claims or orders pending or in effect that would limit or restrict my ability to authorize this disclosure.[2]

Printed Name: _____
Signature: _____
Date: _____

[1] Psychotherapy and Psychiatric Care Records may not be released utilizing this form.
[2] Signers other than the patient/student must present legal documentation that authorizes them to act as a Personal Representative.