

**CONSENT TO RELEASE OF CONFIDENTIAL HEALTH  
CARE INFORMATION FROM W&L**

Patient Name \_\_\_\_\_ Class Year \_\_\_\_\_

DOB \_\_\_\_\_ SSN \_\_\_\_\_

Washington & Lee University  
Student Health Center  
Lexington, VA 24450-2116

May release medical records to:

Person, agency or provider to whom disclosure is to be made: \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Information or records to be disclosed \_\_\_\_\_

\_\_\_\_\_

As the person signing this consent, I understand that I am giving my permission to the above named physician or other named third party for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not redisclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law.

This consent expires on (date) \_\_\_\_\_

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_