

STUDENT HEALTH CENTER

Special Programs Building, 28 Westhampton Way
University of Richmond, VA 23173
Phone (804) 289-8064
Fax (804) 287-6466

Email address: Administrative: healthcenter@richmond.edu Clinical: SHCNurse@richmond.edu
http://oncampus.richmond.edu/student_health
Lynne P. Deane, M.D. and Alene H. Waller, M.D.

TO: _____ Phone# _____
_____ Fax# _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

() I authorize Lynne P. Deane, M.D./Alene H. Waller, M.D. to discuss my _____
_____ with:

Phone # _____

() I authorize the University of Richmond to forward a copy of my medical records to:

Phone # _____ Fax # _____

() Please fax a copy of my _____ to:

Lynne P. Deane, M.D./Alene H. Waller, M.D.
Student Health Center, Special Programs Bldg.
28 Westhampton Way
University of Richmond, VA 23173
Fax # (804) 287-6466
Phone # (804) 289-8064

() My signature verifies that I received a copy of my _____
from the Student Health Center, University of Richmond, VA.

_____ Date

_____ Signature

(If you are a former UR student requesting records, please indicate year of graduation/separation: _____)

_____ Social Security Number

_____ Please Print Full Name
(If different, indicate name as it was when you attended UR)

_____ UR ID #

Date of Birth: _____