

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

NAME: _____
(Indicate maiden or former name if applicable)

ID# / SS#: _____ DATE OF BIRTH: _____

PLEASE FORWARD COPIES OF REQUESTED RECORDS TO:

NAME: _____

STREET: _____

CITY, STATE, & ZIP: _____

Release the following:

___ Entire Health Record ___ Immunization Information Only

___ Specific Dates of Treatment: From _____ to _____

___ Other _____

I am requesting that this protected information be released for the following reason: ("at the request of the individual" is all that is required if you do not desire to state a specific purpose.)

This request is being made because I am transferring care to another primary care provider or leaving the area.

This authorization shall remain in effect _____ (specify date) at which time this authorization to use expires. (up to six mos.)

I also authorize for the release of information regarding assessment, diagnosis, and treatment of alcohol and /or substance abuse.

I also authorize for the release of information regarding diagnosis and or treatment of AIDS or HIV.

SIGNATURE: _____ TELEPHONE # _____
(PATIENT, PARENT OR LEGAL GUARDIAN)

DATE: _____ WITNESS: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the University Health Services, attention Medical Release Correspondent, at the above address.

I hereby authorize University Health Services to disclose my medical information as requested. Information used or disclosed by this authorization may be subject to redisclosure by the recipient and no longer be protected by this rule.

THERE MAY BE A SERVICE CHARGE FOR THE COPYING OF RECORDS