

Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____
Student ID: _____ Patient's phone #: () _____
Date of Request: _____ Date Needed: _____

OR
I authorize the University Health Service to release information to:
Name of Provider or Facility
Address
City, State, Zip Code
Phone #/Fax # (include area code)
I authorize the University Health Service to obtain information from:
Name of Provider or Facility
Address
City, State, Zip Code
Phone #/Fax # (include area code)

PURPOSE FOR THIS REQUEST: (Check one.)
Healthcare Insurance coverage Personal Other
Transfer of Care

TYPE OF RECORDS REQUESTED: (Check one.)
Immunization history
All medical records related to a specific illness or injury.

Specify illness/injury Date(s) of treatment

Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)
Specific information (Select one or more, as applicable)
Procedure report History & physical Physical Therapy Laboratory test results
X-ray reports Other
(Please describe.)
Copy of the entire medical record, as allowed by law.

AUTHORIZATION VALID FOR: (Check one.)
This request only.
One year from the date of this authorization OR . (Insert date.) This authorization applies to the records of the treatment received on or prior to the date of this authorization.
This request and for medical records of any future treatment of the type described above until: Insert Date

I understand that:
My right to healthcare treatment is not conditioned on this authorization.
I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient or Representative _____ Date _____
Relationship to Patient (if requester is not the patient) _____