UNIVERSITY HEALTH SERVICES
AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION

Last Name First Middle Maiden

Address City State Zip

Date of Birth Social Security Number Area Code Phone Number ( )

COPIES SENT FROM/TO

	FROM	TO
Agency/Hospital		
Name & Title of Person		
Street Address		
City, State, & Zip		
Phone & Fax including area code		

INFORMATION NEEDED

- ☐ Inpatient
- ☐ Same Day Surgery
- ☐ Outpatient Clinics
- ☐ Emergency Department

DATES

Pertinent summery documents (*) from the above visits will be sent, unless specific reports are indicated below:

- ☐ Face Sheet*
- ☐ History & Physical
- ☐ Discharge Summery*
- ☐ Operative Reports*
- ☐ Pathology Reports*
- ☐ Consultation Reports*
- ☐ Lab Reports*
- ☐ X-Ray Reports*
- ☐ Test Reports*
- ☐ Therapy Records
- ☐ Emergency Treatment
- ☐ Immunization Records

Other_____

REASON NEEDED

Pertinent summery documents (*) from the above visits will be sent, unless specific reports are indicated below:

- ☐ Medical Care
- ☐ Disability
- ☐ Insurance
- ☐ Legal Reasons
- ☐ Other_____

AUTHORIZATION AND EXPIRATION

This consent will expire in sixty (60) days after the date below, or sooner by my choice in which this consent will expire on:_____

I hereby authorize ☐ University Health Services or ☐ _____
To release the medical information stated above for the reason and time specified.

I give permission to release information concerning treatment, diagnosis, or testing of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC) and/or test antibodies to the AIDS virus (HIV).

_____ _____ _____
Patient/Guardian* Signature Date Witness Signature

* Reason patient is unable to sign_____

_____
(Provide guardianship, executor or estate, power of attorney papers if required.)