UNIVERSITY OF
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UNIVERSITY HEALTH SERVICES

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# AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

Patient: _____ NDID: _____ Date of Birth: _____

Recipient: _____

Address: _____

Purpose of Release: _____

University Health Services ("UHS") is hereby authorized to discuss with and/or release to the "Recipient" information obtained or made in connection with healthcare services provided to Patient through UHS. UHS will not release mental health records, alcohol and/or drug treatment records received from an alcohol or drug treatment program, or communicable disease records ("Sensitive Medical Records") without your specific consent. **However, please note that certain mental health information, substance abuse information or communicable disease information included in your general medical record may be included in any medical records disclosure.**

Initial the chart component/records you are authorizing UHS to release:

___Complete Medical History ___Immunizations ___External Records* ___Sensitive Medical**

*_External Records_ include any record or supporting consultations from providers outside of UHS other than Sensitive Medical Records.

**_Sensitive Medical Records_ include Mental Health, Alcohol/Drug Treatment, and Communicable Disease records generated by third parties that are not embedded in your general medical history as maintained by UHS.

By signing below, I am authorizing UHS to discuss and/or release to Recipient information about my Complete Medical History and/or other medical records, including Sensitive Medical Records, to the extent approved, as reflected by my initials above.

I understand I may revoke this consent at any time except to the extent that action has been taken in reliance thereon. This authorization shall remain valid until the date or event selected below, unless revoked earlier in writing.

___ 180 days from date of signature, **OR**

___ Upon Graduation 20__, **OR**

___ Date of _____.

Signature of Patient (or guardian):_____ Date: _____