



CONSENT TO RELEASE INFORMATION FROM THE MEDICAL RECORD

This authorizes University Health Center to release to:

Name: _____

Address: _____

any and all information contained in the medical record(s) pertaining to my treatment.

Date(s) of treatment: _____

Physician: _____

Name of patient: _____

Current address: _____

Birthdate: _____ Age: _____ Soc. Sec. #: _____

Specific reports to be sent: _____

Reason for disclosure: _____

It is understood by me that this consent is subject to revocation by me at any time except to the extent that action has been taken in reliance thereon. It is also understood that this consent will expire sixty (60) days from the date of signature unless otherwise specified.

Signature of Patient (or guardian): _____

Date: _____

Date of graduation (if applicable): _____