UNIVERSITY OF
NOTRE DAME
UNIVERSITY HEALTH SERVICES

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AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

Patient: _____ NDID:_____Date of Birth:_____

Current Address: _____

Recipient: _____

Address: _____

University Health Services ("UHS") is hereby authorized to discuss with and/or release to Recipient information (including records, reports, tests, histories, diagnosis, prognosis, etc.) obtained or made in connection with evaluation of Patient's medical condition.

Reason for disclosure: Medical History_____ X-ray Films_____ Immunization Records_____
Walk Out Statements_____ Other_____

It is understood by the undersigned that he/she may revoke this consent as to his/her medical records/information at any time except to the extent that action has been taken in reliance thereon. It is also understood that this consent shall remain valid for sixty (60) days from the date of signature ***unless*** the consent is revoked prior to the expiration of sixty (60) days ***or*** a date, event, or condition is designated below upon which the consent will expire:

_____
_____

Signature of Patient (or guardian): _____ Date: _____
Date of Graduation (if applicable): _____

UHS IS NOT authorized to release mental health records/information, alcohol and/or drug treatment records/information or communicable disease records/information ("Sensitive Medical Records") except when reportable by law to public health agencies or unless specifically authorized to do so below.

Sensitive Medical Records Release
By signing below, I am authorizing the above UHS to discuss and/or release to Recipient information about my Sensitive Medical Records, as designated below.

Mental Health _____
Alcohol and/Drug Treatment_____
Communicable Diseases (e.g. – Aids, HIV, hepatitis) _____
Other (Specify) _____

It is understood by the undersigned that he/she may revoke this consent as to his/her mental health records at any time except to the extent that action has been taken in reliance thereon. It is also understood that this consent shall remain valid for one hundred and eighty (180) days from the date of signature ***unless*** the consent is revoked prior to the expiration of one hundred and eighty (180) days ***or*** a date, event, or condition is designated below upon which the consent will expire:

_____
_____

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

Physician's Approval: _____ Date: _____
(Required for Release of Sensitive Information from UHS medical record)