



RELEASE OF MEDICAL INFORMATION

please print clearly

Patient Name: _____ ID#: _____ DOB: _____

Address: _____ City/State/Zip: _____

Phone#: _____

I hereby authorize records FROM:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

I hereby authorize records TO:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

To be shared via:

☐ Mail ☐ Fax ☐ Phone/Verbal ☐ Pick up ☐ Email (immunizations only)

Please include the following information: (Check all that apply)

- ☐ Immunization Records ☐ General Medical Clinical Records
☐ Summary of Mental Health Services ☐ Domestic Violence
☐ Information related to STIs (i.e. HIV), sexual assault, alcohol and drug treatment
(includes information protected by 42 CFR Part II laws protecting alcohol & drug abuse)
☐ Only the following information: _____

I understand:

1. I may revoke this authorization at any time by providing a written notice of revocation as specified by the Notice of Private Practice; however such revocation would not affect any action taken by UHS in reliance on this authorization before receipt of my written revocation.
2. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on whether I provide authorization for any requested use or disclosure by UHS (a) the treatment is research related, (b) the information is needed for health plan eligibility or underwriting determinations or (c) the sole purpose of creating the information is to disclose to a third party.
3. This authorization expires after six months.
4. The information used or disclosed pursuant to this authorization, except information protected by federal regulations about confidentiality of drug and alcohol abuse records, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws.

Signature: _____ Date: _____