University Healthcare Physicians

Date of Request | **UHP Office/Phone #** | **UHP Employee**

I hereby authorize the use or disclosure of protected health information as described below. I understand that this authorization is voluntary. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I authorize _____ **OR**

_____ **to disclose the following information:**
WRITE IN OTHER HEALTHCARE PROVIDER HERE

DATES OF SERVICE_____ **to** _____ **(*cannot be for future dates*).**

This information is to be disclosed (released) *TO* the following individual or entity: Phone _____

_____ _____ **Fax** _____
Name **CURRENT Address**

_____
City, State, Zip Code

Behavioral Health/Psychiatric Care Release Approval
Approved by Clinician(s) _____
Date _____

Select from the following (check as many as apply)

___ **Complete Medical Record**	___ X-ray Reports	___ EKG Reports
___ History & Physical Exam	___ Laboratory Test	___ Consultation Reports
___ Discharge Summary	___ Pathology Reports	___ ER Reports
___ Progress Notes	___ Operative Reports	___ **Demographic Sheet**
___ IMAGING DISC	Other (Please specify) _____	

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Purpose of Disclosure:

___ Continuing Care	___ Referral to Specialist	___ Change of Doctor
___ Insurance	___ Disability Determination	___ Workers Comp
___ Legal Investigation	___ Personal	

This authorization is valid for *releasing the above specified information* to the *above specified individual or entity* for a duration of 6 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

PRINT PATIENT'S FULL NAME | **DATE OF BIRTH** | **ID VERIFIED**

CURRENT ADDRESS | **CITY, STATE, ZIP** | **TELEPHONE #**

Signature of Individual or Personal Representative **Date**

Description of Authority to Act for Individual
Please provide documentation of authority

WITNESS _____