

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)

- | | | |
|--|--|---|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> X-ray Reports | <input type="checkbox"/> EKG Reports |
| <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> Laboratory Test | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> ER Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Demographic Sheet |
| <input type="checkbox"/> 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:

- | | | |
|--|---|---|
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> Referral to Specialist | <input type="checkbox"/> Change of Doctor |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Workers Comp |
| <input type="checkbox"/> Legal Investigation | <input type="checkbox"/> 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 _____