

**AUTHORIZATION TO DISCLOSE HEALTH RECORDS**

Print Patient's Legal Name \_\_\_\_\_ Birth date \_\_\_\_\_ CWID \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

I hereby authorize the use or disclosure of my individually medical/treatment records as described below. Unless explicitly excluded, this Authorization includes any information relating to drug and/or alcohol abuse/treatment, communications with psychiatrists or psychologists or records pertaining to sexually transmitted diseases, if they are a part of my medical record. I understand that this authorization is voluntary. Once this information has been disclosed, it may be subject to re-disclosure and may no longer be protected by federal privacy regulations.

Before the release of any records pertaining to the treatment from a psychiatrists must first be approved by the psychiatrist.

**Releasing Facility**

University of Alabama Student Health Center  
750 Peter Bryce Blvd.  
Tuscaloosa, AL 35401  
Phone 205-348-4678 Fax 205-348-4722

**Receiving Facility:**

Facility: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Self \_\_\_\_\_

These are the records I would like to release: (By initialing below, I specifically authorize the release of the following records, if such records exist)

Dates of treatment to release: \_\_\_\_\_

Date records are needed by: \_\_\_\_\_

\_\_\_ Clinic Notes

\_\_\_ Laboratory records

\_\_\_ Allergy records

\_\_\_ Immunizations

\_\_\_ Gynecology notes only

\_\_\_ Depo injection

\_\_\_ X-ray report /EKG

\_\_\_ Billing

\_\_\_ Pharmacy

\_\_\_ Sexually transmitted disease information

\_\_\_ HIV test results

\_\_\_ Drug/alcohol diagnosis, treatment, or referral information

\_\_\_ AD/HD records

\_\_\_ Psychiatric visits

\_\_\_ Psychological/educational testing (not visit summary)

\_\_\_ Other \_\_\_\_\_

Purpose: \_\_\_ Continued Care \_\_\_ Personal

\_\_\_ This authorization is limited to the following time period \_\_\_\_\_ (be specific).

**This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete this request.**

Date \_\_\_\_\_ Signature of patient \_\_\_\_\_ Telephone number: \_\_\_\_\_

Date \_\_\_\_\_ Witness: \_\_\_\_\_

Office Use: Verified ID \_\_\_\_\_ Number of Pages \_\_\_\_\_