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Authorization to Release or Obtain Health Information

Patient Name: _____ Date Birth: _____

Phone: _____

☐ **I authorize UAD to RELEASE my info TO:** Name: _____

Address: _____

City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____

OR

☐ **I authorize UAD to OBTAIN my info FROM:** Name: _____

Address: _____

City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____

OR ☐ **If releasing information to ME, my medical records should be released via:**

☐ Mail ☐ Pick Up ☐ Fax: _____

The type of info to be released or obtained is as follows:

☐ Progress notes ☐ Consultation notes ☐ Complete health record
☐ Labs ☐ X-ray, CT Scan, MRI, US results ☐ Other: _____

AUTHORIZATION:

I hereby authorize the individual/entity listed above to release my own or my child's records described above, including AIDS/HIV, psychiatric, drug abuse and/or alcohol related information if applicable and use of the information for the purpose of:

I understand that if the recipient of the information is not an entity covered by the federal Privacy Rule, the information used or disclosed as described above, may be re disclosed by the recipient and is no longer protected by the Privacy Rule. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS related information and psychiatric/mental health information. I have been informed that my refusal to grant consent to release of information relating to psychiatric treatment will not jeopardize my right to obtain present or future psychiatric treatment except where disclosure of the communication and records is necessary for treatment.

I understand that I am not required to sign this Authorization as a condition of treatment, payment, enrollment or eligibility for benefits.

I understand that I may revoke this authorization in writing at any time, except to the extent that the above institution has already taken action in reliance on the authorization. Unless I revoke this authorization prior to such time, this authorization shall expire on 12 months

Signature of Patient or Legal Representative: _____ Date: _____

Print Name: _____ Relationship to Patient: _____