UNIVERSITY HEALTH SERVICES
CONSENT FOR RELEASE OF MEDICAL RECORDS TO UHS

Patient Name_____ Date of Birth_____

Address _____ Telephone_____

_____

I authorize _____ to release my medical records to:

Phone:_____

University Health Services
910 Madison Avenue, Suite 922
Memphis, TN 38163
901-448-5630
Confidential Fax 901-448-7255

Fax:_____

_____to _____, and/or only send
(date) (date)

information regarding _____.

I understand that I am not required to execute this release; however, my failure to do so may result in University Health Services not having complete information for treating me.

This authorization expires 60 days from the date below and covers only treatment prior to that date. This authorization may be revoked by my written request except to the extent information has already been released.

_____
Date

_____
Signature

_____
Relationship to Patient