UNIVERSITY HEALTH SERVICES
CONSENT FOR RELEASE OF MEDICAL RECORDS

I hereby authorize University Health Services to release the following information from the records of:

Patient Name_____ Date of Birth_____

Address_____ Telephone_____

_____

INFORMATION TO BE RELEASED

Yes	No	Copy of complete student mental health record (This includes only records of UHS) and not records of other physicians for which UHS may have in your record. To obtain those records, you will need to contact the actual provider of care.)
Yes	No	Documents related to care rendered on (MM/DD/YYYY)_____
Yes	No	SASS – to request testing accommodations
Yes	No	Parents
Yes	No	Spouse
Yes	No	Other (please specify) _____

Any revocation of this authorization shall not apply to the extent that University Health Services, or their agents or employees have previously acted in reliance upon this authorization. I hereby release and agree to hold harmless University Health Services, its agents or employees for any and all release of the foregoing information and documents which are released or delivered in reliance upon this Medical Records Authorization. The foregoing authority shall continue in force and effect until revoked by me in writing. A copy of the original hereof shall be as effective as original.

_____ Date_____

Patient or Legal Guardian

Please hold for pick-up on:_____

Results/Records sent to: _____

_____

_____

_____

UNIVERSITY HEALTH SERVICES
CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient Name_____ Date of Birth_____

Address _____ Telephone_____

_____

I authorize _____ to release my medical records to:

University Health Services
Attn: Christa Deiss
910 Madison Avenue, Suite 922
Memphis, TN 38163
901.448.5064
Or Confidential Fax 901.448.7255

_____ 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