# UNIVERSITY HEALTH SERVICES
# CONSENT FOR RELEASE OF MEDICAL RECORDS FROM UHS

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

PATIENT

Name_____ Date of Birth_____
Address_____ Telephone_____
_____

INFORMATION TO BE RELEASED

_____ Copy of complete medical record (This includes only records of UHS and not records of other physicians for which UHS may have in your medical record. To obtain those records, you will need to contact the actual provider of care.)

_____ Immunization Records

_____ Medical information released to spouse/parent/other (must be specific about to whom and what information is released)._____

_____ Documents related to care rendered on (MM/DD/YYYY)_____

_____ Other:_____

SPECIFIC WRITTEN CONSENT

_____ Copy of results of alcohol testing performed on (date)_____

_____ Copy of results of drug testing performed on (date)_____

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

_____ Date_____
(Witness)

Please hold for pick-up on:_____

Results/Records sent to: _____
_____
_____
_____