THE UNIVERSITY OF ALABAMA® | Division of Student Life
Student Health Center and Pharmacy

AUTHORIZATON 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 identifiable protected health information ("PHI") 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 much first be approved by the psychiatrist.

Releasing Facility

University of Alabama Student Health Center
Box 870360
Tuscaloosa, AL 35401
Phone 205-348-4678 Fax 205-348-4722

Receiving Facility:

Facility: _____
Mailing Address: _____
_____
Phone: _____ Fax:_____

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_____

Revised: August 2017