AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

UTC ID # _____

Patient Identification: Name:_____
Patient Phone #:_____ Date of Birth:_____SSN:_____

Provider: (Who is releasing information)

Release Records To: (Person or Place records should be sent)
Name:_____
Phone:_____ Fax:_____
Address:_____
City:_____ State, Zip:_____

Dates of Treatment: Dates:_____

Information Requested:

__ Hospital Stay
__ Emergency Room
__ Obstetrics and (Labor and Delivery)
__ Psychiatric Hospital or Clinics
__ Clinic:
__ Other (specify):

Purpose of Release:

__ Medical Care __ Insurance __At the request of the patient
__ Other, please explain: _____

I understand that my medical record may also include information on diagnosis/treatment related to psychiatric or psychological conditions, drug and/or alcohol abuse, acquired immune deficiency syndrome (AIDS), and/or HIV status.

I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released.

PLEASE INITIAL THE STATEMENT THAT APPLIES

I do _____ do not _____ authorize this information to be released.

Limitations, if any: _____

Time Limit: I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition _____.

Signature of Patient/ Legal Representative: _____Date: _____

Relationship to Patient: _____