University Health Services
615 McCallie Avenue, Department 6856
Chattanooga, TN 37403
423-425-4453 (o) 423-425-2266 (f)

Name:_____ MR #_____
Please Print

In the event that I, _____, need someone other than myself to obtain my medical records, x-ray films or any other personal or financial information from University Health Services, I give the following person(s) permission to get those records for me: (**please note that physicians need not be listed**)

1._____ 4._____

2. _____ 5. _____

3. _____ 6. _____

I understand that I may limit access to specific records. I choose to allow the above named persons to obtain the following types of records:

X-rays	Yes	No
Prescriptions	Yes	No
Insurance/Financial Information	Yes	No

I authorize University Health Services to leave personal and/or billing information on my answering machine or voice mail. Yes No

By signing this release, I agree the University Health Services will not be held liable for any medical information that has been released to the above mentioned person(s), devices concerning the designated information.

_____ _____
Patient or Legal Guardian (Print) Date

_____ _____
Patient or Legal Guardian (Signature) Date

_____ _____
Witness Date

This information shall be in effect until revoked by the patient