AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

UTC ID # _____

Patient Identification:

Name: _____

Patient Phone #: _____ **Date of Birth:** _____

Provider: (Who is releasing the information)

Name:

Phone: _____ **Fax:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Release Records To: (Person or Place records should be sent)

Name: _____

Phone: _____ **Fax:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Dates of Treatment: _____

Information Requested:

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

Purpose of Release:

___Medical Care ___Insurance ___At the request of the patient
___ Other, please explain:

Authorization:

- 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: _____

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