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**UNION UNIVERSITY HEALTH SERVICES**

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**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Student ID # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

I request and authorize **Union University Student Health** to release healthcare information of the above named patient to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

This request and authorization applies to:

\_\_\_\_\_ Healthcare information relating to the following treatment, condition or dates: \_\_\_\_\_

\_\_\_\_\_ All healthcare information

\_\_\_\_\_ Immunization record: \_\_\_\_\_

\_\_\_\_\_ Other

\_\_\_\_\_ Yes \_\_\_\_\_ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED**

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