



# UNION UNIVERSITY

HEALTH SERVICES

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## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Previous Name: \_\_\_\_\_ Last 4 of SSN: \_\_\_\_\_  
Student ID# \_\_\_\_\_ Cell Phone# \_\_\_\_\_

I am requesting my medical records from:

Facility Name:			
Address:			
City/ST Zip:			
Phone #		Fax#	

This request and authorization applies to:

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

\_\_\_\_\_ Entire Record \_\_\_\_\_ Imaging / X-Ray Reports & Films \_\_\_\_\_ Lab Results

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

\_\_\_\_\_ Other

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

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

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED

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