



Authorization for Release of Medical Information

I hereby authorize the release of information from the medical record of:

Patient Name: _____ Date of Birth: _____

Social Security #: _____ STMU ID# _____ Daytime Phone #: _____

Information Released To: _____ **From:** _____

Please Release the Following:

- | | |
|--|---|
| <input type="checkbox"/> Problem List | <input type="checkbox"/> X-Ray Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> X-Ray Films |
| <input type="checkbox"/> History/Physical Exam | <input type="checkbox"/> EKG Reports |
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Other Diagnostic Reports (Specify) _____ |
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> Other (Specify) _____ |

Including information (if applicable) pertaining to:

Mental Health Drug/Alcohol HIV/AIDS Communicable Treatment

Purpose of Need for Disclosure:

- | | |
|---|--|
| <input type="checkbox"/> Continued Patient Care | <input type="checkbox"/> Personal Use |
| <input type="checkbox"/> Attorney/Legal | <input type="checkbox"/> Insurance Claim/Application |
| <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Other (Specify) _____ |

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

Signature of Patient or Legal Representative Date

Relationship to Patient Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.

I will not hold St. Mary's University Student Health Center liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative Date

Relationship to Patient Witness

Date request completed _____ # pages copied _____ Initials _____