AUTHORIZATION TO RELEASE/REVIEW HEALTH INFORMATION

University Physicians, Inc.

Our practice ("PA") will not release your health information without your permission, except as provided in our Notice of Privacy Practices. This form means you are giving permission for us to obtain, release or disclose your information as described below.

I hereby request _____ to ☐ release my health information.
☐ allow me to review my health information.

Please obtain my health information from: _____
Phone: _____ Fax: _____
Address: _____

Patient Name_____ Date of Birth_____
Address_____
Medical Record Number_____ or Social Security Number_____

Describe what health information is requested (check all that apply): **Copying charges may apply**

__ Demographics (e.g. name, address, phone #, etc.)
__ History/Physical Exam
__ Progress Notes
__ Laboratory Results
__ Pathology Reports
__ Immunization Records

__ X-Rays or Reports: _____
_____
__ Photo/Image: _____
_____

__ Consultation Reports
__ Discharge Summary
__ Operative Notes
__ Mental Health Records
__ Billing Records
_____

__ Complete Health Record
Please include (check one) :
HIV Test Results ___ Yes ___ No
Psychotherapy Notes ___ Yes ___ No
Drug/Alcohol Abuse Notes ___ Yes ___ No

__ Other (please specify): _____
_____
_____
_____
_____
_____

Records from (date) _____ to _____

Please release health information to:

Name_____

Address _____

Phone_____ Fax_____

The information will be released for the following purpose(s):

___Request of Patient ___ Treatment ___ Insurance ___Other (Please specify) _____

Signature: _____ **This authorization is valid for this request only.**

Please Print Name: _____ Today's Date: _____

Indicate relationship if other than patient: _____

For Office Use Only	**Completed by:**
Access Denied	Approved
Reason Denied	Date Provided
Date Notice of Denial Sent:	Date Accessed/Reviewed:
Copying Charges:	