HIPAA Communication Preferences Authorization

Name: _____ Date of Birth: _____

Release of Information

I hereby authorize UofL Campus Health Services to discuss and/or release my medical information including but not limited to my diagnoses,billing, test results, progress notes, condition and/or treatments with the following individuals:

Name	Relationship	Phone Number

Withhold Information

I do not wish UofL Campus Health Services to discuss or release my medical information to the following individuals:

Name	Relationship	Phone Number

This authorization will expire on ___/___/___ or in one year if not specified.

_____ _____

Patient Signature **Date**