U of L Campus Health Services

Authorization for Release of Medical Records

Health Sciences Center Office

401 East Chestnut Suite 110
Louisville, KY 40202
VOICE: 502-852-6446
FAX: 502-852-6649

Please send a copy of this release with the requested records.

PATIENT INFORMATION (Please print)			
Patient Name		Date of Birth	Student ID Number
Address	City/State	Zip	Phone

RELEASE FROM: Name of physician or facility releasing information		
Physician/Facility		
Address	City/State	Zip

My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization:

	FULL MEDICAL RECORD including HIV, AIDS, treatment for drug or alcohol abuse, mental health and/or psychiatric treatment		
	Or other records as specified below:		
	HISTORY AND PHYSICAL EXAM		CONSULTATIVE REPORTS
	HOSPITAL AND/OR OPERATIVE REPORTS		X-RAY REPORTS
	IMMUNIZATIONS ONLY		PROGRESS REPORTS
	LABORATORY TESTS		STIMULANT/NARCOTICS RECORDS
	DISCHARGE SUMMARY		OTHER (PLEASE LIST)
	PHOTOS, VIDOETAPES, DIGITAL IMAGES		

I understand that this information include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection, treatment for drug or alcohol abuse, or mental/behavioral health or psychiatric care.

I have reviewed and understand the following:

- I understand that, if my health information is disclosed to someone who is not required to comply with the federal privacy regulations, then that information could be re-disclosed and would no longer be protected.
- I understand that I may revoke this authorization at any time by writing a letter to U of L Campus Health Services at the above address. I am aware that my revocation cannot affect those who were already authorized to use/disclose my protected health information, according to this authorization, prior to my revocation.
- Unless otherwise revoked, I understand that this authorization is valid for 180 days from the date signed or on the following date or event ___________________________________.
- I understand that I do not have to sign this authorization as a condition of being treated by University of Louisville Campus Health Services
- The protected health information being used and/or disclosed under this authorization is for the following purpose (you may leave this blank if you are the patient or the patient's legal guardian and the protected health information is being released to you.)
  ❑ Patient Care ❑ Other: ____

Each patient may receive one copy of their medical record per 12 month period at no charge. If you require additional medical records in a 12 month period, you will be charge $1.00 per page.

Signature of patient or patient's representative	Date
Printed name of patient or patient's representative, given authority to act for patient	Relationship