U of L Campus Health Services
Authorization for Release of Medical Records

***HSC OFFICE 502-852-6446 FAX 502-852-6649 401 E. CHESTNUT STREET, STE 110 LOUISVILLE, KY 40202**

***CARDINAL STATION 502-852-6479 FAX 502-852-0660 215 CENTRAL AVE , STE 110, LOUISVILLE KY 40208**

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	Zip	Phone

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

RELEASE TO: The authorized person/entity to request & receive the information in this authorization			
Physician/Facility SELF—PLEASE INITIAL_____			
Address	City/State	Zip	Phone: Fax:

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

	FULL MEDICAL RECORD		
	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		OTHER (PLEASE LIST)
	DISCHARGE SUMMARY		
	PHOTOS, VIDOETAPES, DIGITAL OR OTHER IMAGES		

CONSENT:

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.)

  _____

  _____

I understand that I may be charged for copies provided. (Each patient may receive one copy of medical records 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

REVISED: 09/27/2010 / T. Cooper RN