THE UNIVERSITY OF ALABAMA® | College of Community Health Sciences
Student Health Center and Pharmacy

AUTHORIZATON TO DISCLOSE HEALTH RECORDS

Print Patient's Legal Name________________________________ **Birth date** _____________**CWID**____________________________

Address: ____ **City** ___________________________**State:** ___________ **Zip** ________

I hereby authorize the use or disclosure of my individually identifiable medical/treatment records as described below. Unless explicitly excluded, this Authorization includes any information relating to drug and/or alcohol abuse/treatment, communications with psychiatrists or psychologists or records pertaining to sexually transmitted diseases, if they are a part of my medical record. I understand that this authorization is voluntary. Once this information has been disclosed, it may be subject to re-disclosure and may no longer be protected by federal privacy regulations.

Before the release of any records pertaining to the treatment from a psychiatrists much first be approved by the psychiatrist.

Releasing Facility

University of Alabama Student Health Center
750 Peter Bryce Blvd.
Tuscaloosa, AL 35401
Phone 205-348-4678 Fax 205-348-4722

Receiving Facility:

Facility: ____
Mailing Address: _________________________________
____
Phone: ___________________ **Fax:**__________________

Self_____________ **Patient Portal** ___________

These are the records I would like to release: (**By initialing below**, I specifically authorize the release of the following records, if such records exist)

Dates of treatment to release: ________________________ **Date records are needed by:** ____________________

____ □ Clinic Notes
____□ Laboratory records
____□Allergy records
____□ Immunizations
____□ Gynecology notes only
____□ Depo injection
____□ X-ray report
____□ Billing

____ □ Pharmacy
____□ Sexually transmitted disease information
____□ HIV test results
____ □ Drug/alcohol diagnosis, treatment, or referral information
____ □ AD/HD records
____□ Psychiatric visits
____□ Psychological/educational testing (not visit summary)
_____ Other ____

Purpose: □ Continued care □ Personal use

_____□ This authorization is limited to the following time period ____________________________________ (be specific).

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete this request.

Date ______________ **Signature of patient** ____________________________________ **Telephone number:** __________________

Date______________ **Witness:** ____

____

Office Use: Verified ID __________ Number of Pages___________

Reviewed: January 2022