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** _____**SS#** _____

I hereby authorize the use or disclosure of my individually identifiable medical/treatment records as described below. 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 the psychiatrist they must first be approved by the psychiatrist.

Releasing Facility

The 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) Any unmarked records will be withheld.

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 □ Other _____

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

This authorization may be revoked at any time. The only exception is if action has been taken in reliance on the authorization prior to revocation. 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, whichever occurs first.

Date _____ **Signature of patient** _____ **Telephone number:** _____

Date_____ **Witness:** _____

_____

Office Use: Verified ID _____ Number of Pages_____

Revised: October 2025