Manchester University Health Services

Authorization For Release Of Medical Information

Patient's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____

Social Security Number: _____

The undersigned hereby authorizes_____
to release the following portions of the medical records of the above named patient during the time period of:_____

____Discharge Summary	____Lab Reports	____Emergency 'Treatment
____History & Physical	____X-ray Reports	____Other, Specify_____
____Surgery Report	____Pathology Report	____Immunization Record

Release This Information To:

Name: _____ Phone: _____
Address: _____ Fax: _____
_____ ATTN: _____

The Medical Record is needed for the following purpose:

____Attorney	____Insurance
____College Enrollment	____Personal
____Continued Medical Treatment/F/U	____Workman's Compensation Claim
____Disability	____Other_____
____Employer	

I understand that I may revoke this release at any time, in writing, but the request shall remain valid until revoked or upon the expiration of sixty (60) days, whichever occurs first, except to the extent that action has been taken thereon.

I also understand that this release may include medical records of treatment for physical and/or emotional illness, including treatment of alcohol or drug abuse. I also understand that HIV, AIDS or AIDS-related and/or communicable disease information may also be released.

Signature_____ Date_____

Witness _____ Relationship_____