Southern Adventist University Health Center
Medical Release Authorization

Patient Name	Birth Date	Social Security #
Address	Home Telephone: ( ) Alternate Telephone: ( )	

I hereby authorize: _____
Name of Individual/Organization who is being asked to release records
Address: _____
_____
Phone: _____ Fax: _____

To release the below requested medical information to:

□ University Health Center
Southern Adventist University
PO Box 370
Collegedale, TN 37315
Phone: 423-236-2713
Fax: 423-236-1713
E-mail: uhc@southern.edu

□ Name of Person/Organization: _____
Address: _____
_____
Phone: _____ Fax: _____

Purpose of Disclosure: (reason must be provided)	For the following treatment dates:
□ At the request of the individual signing this authorization □ Other (Specify): _____	□ All dates of treatment □ For dates of treatment from _____ to _____
Specific description of information to be disclosed: □ Immunization records □ All medical records for the time period indicated □ Other (Specify): _____ The records are to be: □ Faxed □ Mailed □ E-mailed □ Picked up	Individual authorization required for each of the following: □ Mental Health Record □ Sexual Assault/Victimization Records □ Drug/Alcohol Treatment Records □ AIDS/HIV Signature: _____ Date: _____

I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization in writing at any time by sending the revocation to the health care provider indicated above, unless the provider has already taken action in reliance on this authorization. Aside from this, I understand that upon expiration of the authorization, no further disclosure of the information may be made. I understand that a health care provider may decline to treat me if I refuse to sign this authorization only when the treatment is for the sole purpose of creating health information for disclosure to a third party. I further understand that the records to be released may contain or consist of information related to the following: contagious diseases (HIV/AIDS, TB, hepatitis, etc.); psychiatric treatment or psychotherapy; and drug/alcohol treatment.

_____ _____ _____
Date Signature of Patient (Parent/Legal Guardian if under age 18) Relationship to Patient

This authorization expires 90 days from the date specified above or the date on which the requested release of information has been completed, whichever comes first. This release covers records of treatment only for the dates specified above. Fees/charges will comply with all laws and regulations applicable to release of information. This authorization can only be honored when all portions have been completed.

For Office Use Only:
□ Faxed □ E-mailed □ Mailed □ Released to patient

_____ _____
Date Sent by