University Health Center

Southern Adventist University

PO Box 370 Collegedale, TN 37315 Phone: 423.236.2713 Fax: 423.236.1713 uhc@southern.edu

Medical Release Authorization

Patient Name (list any and all names used when attending SAU)	Birth Date	Southern ID
Phone Number	Year of most recent Southern attendance	

I hereby authorize:

□ The University Health Center at Southern Adventist University

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

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: _____ Email: _____

For the following treatment dates:

□ All dates of treatment □ For dates of treatment from _____ to _____

Specific description of information to be disclosed:

□ Immunization/TB Screening 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 disclosures:

□ Mental Health Record □ 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.

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

This authorization expires 365 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