Universality Health Care Clinic
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HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION/Authorizing Universality Health Care to Release medical Records

Patient Name:
Date Birth:
Address:

All records of treatment for psychiatric/mental health, chemical dependency and AIDS/HIV-related illness or testing will be released

Please release my records to: (Who needs your records? Where do you want the information sent?) Name: _____ Phone: _____ Fax: _____
Address:_____City:_____State:_____
Zip:_____

Delivery Method: All forms of record delivery is acceptable
I understand that If I change my mind, I may write to the address in Section 1 to stop the release of my records. This will not apply to records that have already been released. Once the records are released to the name above, the place releasing my records cannot prevent them from being shared with a third party. At that point, the records may no longer be protected by state and federal privacy laws. My records may include records that you received from other organizations. If you have used these records and filed them in the record you maintain about me, then they may also be included in any release of information. I approve the release of records for future visits, starting from the date I sign this form through: There may be a fee for releasing these records.

A photocopy of this completed, signed form is considered valid if not altered. I understand that, except for research related treatment, you will not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. This form expires one year after I sign it, or except in certain situations specified by law.

Signature of patient or authorized person If authorized person, print name and description of authority to sign for patient (may require proof

Patients Print name/signature/date
Authorized Signer Print name/Relationship/signature/Date