AUTHORIZATION TO RELEASE MEDICAL RECORDS

131 Millennium Student Center
One University Boulevard
St. Louis, MO 63121-4400
Office: 314-516-5671
Facsimile: 314-516-5988

✓ Please check the appropriate box(es) and fill in the blank(s) as needed.

Patient's Full Name: _____ Phone Number: _____

Former Names(s) (where applicable):_____

Date of Birth: _____ Student/Staff ID# : _____

I hereby authorize my medical records to be released to / obtained by the University of Missouri-St. Louis Student Health Services as follows:

☐ History & Physical ☐ Laboratory ☐ Clinic Records ☐ Immunization ☐ Psychiatric

☐ Other: _____

Purpose for release of records: _____

_____

Date(s) of Treatment: _____

Release or Mail To: Individual/Physician/Institution/Agency : _____

Street Address : _____

City, State and Zip Code: _____

Telephone Number: _____

Fax Number : _____

I understand that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will expire ninety (90) days from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I must mail, fax or bring a letter in person stating that I want to cancel this authorization. I understand that I need to mail, fax or bring the letter to the address or fax number noted at the top of this page.

Patient/Requester Signature: _____ Date:_____

RECORDS WERE RELEASED AS REQUESTED ABOVE BY:

_____ _____

Signature of UHS Staff **Date**