***Lipscomb University Health Services Fax: (615)966-5286 Phone: (615)966-6304***

**RELEASE OF STUDENT MEDICAL RECORDS FROM**

**LIPSCOMB UNIVERSITY**

This authorization is for Lipscomb University Health Services to disclose protected health information to other health care providers or health plans for medical care, insurance, or for personal reasons. If you want to amend this release, it is your responsibility to make the effective changes.

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(name), hereby give permission for Lipscomb University Health Services to release information from my medical records to:

Name of provider or institution:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*Note we only fax or mail records.*

Medical records may include information about diagnosis/treatment of psychiatric or psychological conditions, drug and/or alcohol abuse, and HIV/AIDS status. If you do NOT wish for information pertaining this to be released please initial here. \_\_\_\_\_\_\_\_\_\_

If there are limitations on the kind of information we release to an outside healthcare associate please list here:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**YOUR RIGHTS WITH THIS AUTHORIZATION:**

You may inspect the health information to be used or disclosed by this authorization form. This must be arranged by the Student Health Director. You have no obligation to sign this form. You can revoke this authorization at any time by written notification. For further information, you may contact the Student Health Director.

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_Phone: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Graduated \_\_\_May \_\_\_Aug. \_\_\_Dec. \_\_\_\_\_\_year or Last date of enrollment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_

Witness Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_