AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Please fully complete and sign this form.

Patient Information:

Name (Last, First, Middle)_____

Address_____

Phone_____ Student ID_____ Date of Birth_____

Authorization

Patient hereby authorizes TIU Health Services to:

☐ Release Information to: ☐ Request Information from: ☐ Mutually Exchange Info with:

Name _____ Phone: _____

Address _____ Fax: _____

_____

City _____ State _____ Zip Code _____

Type of Disclosure: ☐ Verbal Communication ☐ Copies of Records (Please note, when possible, and unless otherwise requested, copies will be released electronically)

Health Information Authorized to be Released (Please check all that apply.)

☐ ALL MEDICAL RECORDS

☐ Immunization Records only

Purpose of Release

Please state the purpose for the request: ☐ Continuity of Care ☐ Legal Matter ☐ Personal Use

☐ Other: _____

A copy of this Authorization shall be valid as an original.

_____ _____

Signature of the Patient or patient's legal representative Date

_____ _____

Printed name of signatory Relationship to patient (if signed by other than patient)

TIU Health Services
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