

# Authorization to Release Health Care Information from UAH Health Clinic

Patient's Name: \_\_\_\_\_

Previous Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_

**I request and authorize the release of my health care information as specified below:**

From:

Name: UAH Health Clinic

Address: University of Alabama in Huntsville, 301 Sparkman Drive, Wilson Hall 327

City: Huntsville State: Alabama Zip Code: 35899

Phone: (256) 824-6775 Fax: (256) 824-6722 or Immunizations@uah.edu

To:

Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

This request and authorization applies to:

- Immunization Records Only - Email to: \_\_\_\_\_
- Health care information relating to the following treatment, condition or dates: \_\_\_\_\_
- All health care information
- Other: \_\_\_\_\_

*Definition: Sexually Transmitted disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (acquired immunodeficiency syndrome) and gonorrhea.*

Yes    No    I authorize the release of my STD results, HIV/Aids testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes    No    I authorize the release of any records regarding drug, alcohol or mental health treatment to the individual or health care entity listed above.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED**