

**Midwestern State University
Vinson Health Center**

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: (print) _____

Address: _____

Social Security No: _____ Date of Birth: _____

1. Information to be Released:

_____ Copy of entire medical record (This will include drug, alcohol, mental health or communicable disease related information such as HIV [AIDS] test results, if any)

_____ Include copies of documents which were not done at the Vinson Health Center (e.g., Hospital records, outside lab and x-ray test, etc)

_____ Other (specify) _____

2. Requesting Records from: Include Phone number: _____

3. The above information may be released to: _____

4. The reason for release of information is (please be specific):

coordination of care

5. I understand that my records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law.

6. I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it and that, in any event, this authorization expires automatically as described below.

7. This authorization will expire sixty (60) days from the date of my signature unless otherwise specified by date, event, or condition as follows:

DATE: _____

SIGNATURE: _____
(Patient or legal representative)

WITNESS: _____