HEALTH RECORDS REQUEST/RELEASE AUTHORIZATION

PLEASE FILL OUT THE FORM COMPLETELY

Patient Name (Please Print) _____ Date: _____
Last Name/ First Name/ M.I./ Maiden (if applicable)

Social Security # _____-_____-_____ Birth Date _____ /_____ / _____
Month Day Year

Current Address _____
City _____ State _____ Zip _____
Phone # (_____) _____

I HEREBY AUTHORIZE UNITY HEALTHCARE, LLC TO RELEASE MY HEALTH RECORD(S) TO:

Provider's Name: _____

Provider's Address: _____

_____
City State/Zip Code

Purpose for release: _____

The information you authorize for release may include information regarding mental health, drug or alcohol use/abuse, communicable diseases, pregnancy, and HIV/AIDS.

PLEASE CHECK APPLICABLE REQUEST:

_____ **ALL** Health Record(s) (may include mental health, drug or alcohol use/abuse, communicable diseases, pregnancy and HIV/AIDS)
_____ Only pregnancy related information from _____ to _____
_____ Only gynecological information from _____ to _____
_____ Only X-rays/lab results from _____to _____
_____ Only prescriptions from _____ to _____
_____ Other - Please specify information to be released: _____

This Authorization shall expire ninety (90) days from the date of its execution or upon my express revocation, whichever occurs earlier. Such revocation shall become effective immediately, except to the extent that Unity Healthcare, LLC has taken actions in reliance on it.

_____ _____
Patient Signature Date

_____ _____
Parent or Guardian Signature Date

Record released by: _____ Date: _____