

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL RECORDS

PLEASE PRINT

Name: _____	Date of Birth: _____
Address: _____	City/State/Zip: _____
Phone: () _____	NU ID: _____

SPECIFIC INFORMATION TO BE RELEASED OR OBTAINED:

- | | |
|---|---|
| <input type="checkbox"/> Immunization Records:
Graduation year _____ | <input type="checkbox"/> Complete Records |
| <input type="checkbox"/> Psychiatric Care/Mental Health | <input type="checkbox"/> Other: _____ |

<p>RELEASE MY RECORDS TO:</p> <p><input type="checkbox"/> Me</p> <p><input type="checkbox"/> Name: _____</p> <p>Address: _____</p> <p>City/State/Zip: _____</p> <p>Phone #: () _____</p> <p>Fax #: () _____</p>	<p>OBTAIN MY RECORDS FROM:</p> <p><input type="checkbox"/> Name: _____</p> <p>Address: _____</p> <p>City/State/Zip: _____</p> <p>Phone #: () _____</p> <p>Fax #: () _____</p>
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Please **FAX** records to UNO Student Health Services at **(402) 554-2387**,
MAIL to the address listed below.

I understand this authorization may be revoked in writing at any time, except to the extent that action had been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 180 days after the date of execution by the patient or their representative.

I may request a copy of this authorization. If I do not sign this form, UNO Student Health Services will not release my information to any person or organization except those authorized by the law. My health care or payment for care will not be affected by my refusal to sign. Once disclosed, Federal privacy regulations will no longer apply and the information may be subject to redisclosure. A photocopy of this authorization is as valid as the original.

Signature: _____ **Date:** _____ **S.H.S. INITIAL** _____