RELEASE OF HEALTH INFORMATION

With this form, you allow the release of your medical health information. Complete all fields and return to: Carnegie Mellon University Health Services, 1060 Morewood Ave. Pittsburgh, PA 15213, Fax Number: 412 268 6357. Send questions to health@andrew.cmu.edu.

____________________ Last Name
____________________ First Name
________ Middle Initial

____/____/________ Birthdate (mm/dd/yyyy)
____________________ Email Address
____________________ Phone Number

____________________ Address

Carnegie Mellon University Health Services will send your information to/receive your information from:

____________________ Name of facility or person

____________________ Address

____________________ Phone Number
____________________ Fax Number

☐ **Consent to Unencrypted Email Communication.** By checking this box, I acknowledge and understand that the communication of my medical health information via unencrypted email may not be fully secure and could be subject to interception. Despite those inherent risks, I hereby give permission to Carnegie Mellon University Health Services to send my personal health information via unencrypted email to the person or facility listed on this Release of Health Information.

What information should be released? Only checked items will be included.

- ☐ Immunization records
- ☐ All medical records **except sensitive documents** (substance use, domestic violence, sexual assault, HIV, mental health)
- ☐ Include drug and alcohol information
- ☐ Include HIV/AIDS information
- ☐ Include domestic violence or sexual assault information
- ☐ Include mental health information (shared between providers only)
- ☐ Include medical records from other facilities
- ☐ Other (please specify): ____________________

Consent expires: ____/____/________ (mm/dd/yyyy)

This consent must have a time limit that does not exceed one year from Client's signature date below. If left blank, consent expires 90 days after Client's signature date. Client may terminate this consent at any time by sending a written request to Carnegie Mellon University Health Services. Termination will cancel future actions, but cannot reverse the release of information already completed.

____________________ Dates of service for which you would like information released

____________________ Reason for the release of information

I grant my permission for the release of information I've specified above. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

____________________ Client's signature
____/____/________ Date (mm/dd/yyyy)

____________________ Authorized representative's signature
____________________ Relationship to client
____/____/________ Date (mm/dd/yyyy)

Signature of Facility staff member who completed the release, and date completed: ____________________