

# CONSENT FOR RELEASE OF MEDICAL INFORMATION

With this form, you authorize the release of your medical health information. Print neatly and complete all fields. Questions may be emailed to: [health@andrew.cmu.edu](mailto:health@andrew.cmu.edu)



## IDENTIFY YOURSELF (you are the client)

Client's Last Name	First Name	MI	Date of Birth (mm/dd/yyyy)
Address			
9-digit Carnegie Mellon Student Account # (This is your SS#, or a 9-digit number starting with 999 or 700.)	Email address		Phone #
Please indicate the semester and year when you last attended. (ex: Spring, 2007) _____			

## IDENTIFY THE FACILITIES SENDING AND RECEIVING YOUR MEDICAL INFORMATION

Carnegie Mellon University Health Services 1060 Morewood Ave, Pittsburgh, PA 15213 Phone: (412) 268 2157 Fax: (412) 268 6357  You may specify a particular staff member here if you wish: _____	<input type="checkbox"/> is sending information to	Name of facility or person:
	or	Address:
	<input type="checkbox"/> is receiving information from	Phone: Fax:

## SPECIFY THE INFORMATION TO BE RELEASED

Reason for the release of info? _____	Consent expires on: _____ (mm/dd/yyyy)
For what dates of service do you want info released? _____	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.
What categories of information do you wish to have included? Only those items checked will be included. <input type="checkbox"/> Immunization records and health history only <input type="checkbox"/> All medical records <b>except sensitive documents</b> (substance or alcohol abuse, domestic violence, sexual assault, HIV related, mental health) <input type="checkbox"/> Include drug and alcohol information. <input type="checkbox"/> Include HIV or aids information. <input type="checkbox"/> Include domestic violence or sexual assault information. <input type="checkbox"/> Include mental health information. <input type="checkbox"/> Include medical records from other facilities. <input type="checkbox"/> Other (please specify): _____	
Client may terminate this consent at any time by sending a written request to the facility/person identified above to release records. Receipt of a termination request will cancel future actions, but cannot reverse the release of information already completed.	

## CERTIFY THIS REQUEST

I grant my permission for the release of information I've specified above. I understand that information being disclosed to a party outside of UHS may be re-disclosed by that party. UHS and its employees have no responsibility or liability as a result of re-disclosures.

Client's signature (if not 18, an Authorized Representative must sign below)	Date Client signed (mm/dd/yyyy)
Authorized Representative's signature	Authorized Representative's relationship to act on behalf of client
	Date Auth. Rep. signed (mm/dd/yyyy)
Signature of a Facility Staff Member witnessing this signature of Client	Date Witness signed (mm/dd/yyyy)

**Witness must verify client's identity via photo id. If form is received by FAX, verification is to be done by phone, via SS#, visit history, etc.)**

**RETURN THIS FORM TO:** Carnegie Mellon University Health Services, 1060 Morewood Ave, Pittsburgh, PA 15213 FAX:412 268 6357

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