Carnegie Mellon University
University Health Services

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Last Name _____ Patient First Name _____

Patient Birthdate (mm/dd/yyyy) ____/____/_____ Patient Email Address _____ Patient Phone Number _____

Facility/Person to Receive Records:

Name of facility or person _____

Mailing Address _____

Phone Number _____ Fax Number (healthcare providers only) _____

Email Address (if emailing records) _____

Purpose of Release: ☐ Medical Care ☐ Educational Requirement ☐ Legal ☐ Insurance ☐ Personal

Method of Release: ☐ US Mail ☐ In-Person Pickup ☐ Fax ☐ Email*

** **Consent to Unencrypted Email Communication.** By checking the email box above, 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 authorization form.*

Dates of Service for Which You Would Like Information Released: _____

Type of Information to be Released: ☐ Immunization Records ☐ Lab Reports/Tests ☐ Radiology Reports ☐ Office Visit Notes ☐ Other (specify): _____

HIV-related information contained in the parts of the records requested above will be released through this authorization unless otherwise indicated. ☐ Do not release.

For Psychiatry and/or Psychotherapy records, contact CMU Counseling & Psychological Services: 412-268-2922.

Consent expires: ____/____/_____

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.

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 (if applicable) _____ Relationship to client _____ Date (mm/dd/yyyy) ____/____/_____

Complete all fields and return to: Carnegie Mellon University Health Services, 100 Tech St., Floor 3, Pittsburgh, PA 15213
Fax Number: 412 268 6357 | Email: health@andrew.cmu.edu.