University of Rochester
University Health Service
www.rochester.edu/uhs

Completed forms should be returned Attn: Medical Records
Email- HHF@uhs.rochester.edu
Fax- 585-756-0263
Mail- University Health Service 738 Library Rd, Box 270617, Rochester NY 14627

Authorization for Release of Medical Information

For the release of medical records from the University of Rochester Medical Center (URMC) / Strong Memorial Hospital (SMH), call 585- 275-2605

Patient's name: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____ Patient's phone #: ( ) _____
Email Address: _____ Student ID: _____
Date Needed: _____ Forward Records to: _____ (Provider/MD/NP Name)

This Authorization allows University Health Service to: (check one or both)

- ○ **SEND copies of your record to the provider/person/facility below**
- ○ **REQUEST copies of your record from the provider/person facility below**
- ○ **Exchange of Verbal Communication with the provider/person below**

Name of Provider/Person/ facility _____

Address _____

City/State/Zip Code _____

Phone# (include area code) _____ **Fax#** _____

PURPOSE FOR THIS REQUEST: ☐ Healthcare ☐Insurance coverage ☐Transfer of Care ☐Personal ☐Other

TYPE OF RECORDS REQUESTED: (Check one.) ☐ **Copy of the entire medical record, as allowed by law.**

☐ All medical records related to a specific illness or injury**.**

_____
Specify illness/injury Date(s) of treatment

Specific information/Treatment Summary (Select one or more, as applicable):

☐ Immunization history ☐ History & Physical ☐ Physical Therapy ☐ Laboratory Test Results ☐ X-ray reports

☐ Behavioral Health (**UHS provider info. only**) ☐ Other _____
(Please describe)

AUTHORIZATION VALID FOR: (Check one.)

☐ This request only ☐ One year from the date of this authorization **OR** _____. (Insert date.)

☐ This request **and** for medical records of any **future** treatment of the type described above until: _____ (Insert Date)

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a ***written*** request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

Signature of Patient or Representative _____ Date _____

Relationship to Patient *(if requester is not the patient)* _____