

**AUTHORIZATION TO RELEASE
INFORMATION TO UCF HEALTH SERVICES**

NAME OF PHYSICIAN OR PRACTICE: _____

ADDRESS: _____

TELEPHONE: _____

FAX: _____

I HEREBY AUTHORIZE THE ABOVE TO RELEASE THE FOLLOWING RECORDS TO THE UCF HEALTH SERVICES:

- Office Visits _____
- Lab Results _____
- X-Ray Results or Films _____
- All Medical Records _____

This information will include mention of or testing of drug abuse, alcohol abuse, psychiatric records, HIV testing and/or AIDS.

Exclude mention of or testing of:

- | | | |
|--|--|---|
| <input type="checkbox"/> HIV and/or AIDS | <input type="checkbox"/> STD | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Psychiatric Records | <input type="checkbox"/> Sexual Assault Records |

I UNDERSTAND THAT THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM DATE SIGNED.

Signature

Date

Print Name

Social Security Number

Witness

Date

Copied/Sent By

Date

SENT: ____ Yes ____ No FAXED: ____ Yes ____ No HANDCARRIED: ____ Yes ____ No
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*****CONFIDENTIALITY NOTICE*****

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**UCF Medical Records, P.O.Box 163333, Orlando, FL 32816-3333
Tel (407) 823-2091 or fax to (407) 823-3359**