

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Step 1: Information about you:

Name: _____ Date of Birth: _____
Last First MI Other names (maiden)
Address: _____ BC ID# _____
Street City State Zip
Tel (cell) number: _____ Fax: _____ E-Mail: _____
Student Status: Undergrad Graduate Transfer Evening Year started: _____ Year Graduated: _____

Step 2: To whom do you wish to release your records to:

Name of Person/Facility, Address, Phone or fax number as applicable

Release the following Information:

Entire Medical Record Immunizations only Other: _____ Specific Dates: From _____ to _____

Step 3: Authorization and Signature

I hereby authorize _____ to release the records as described above. This authorization is valid for 90 days and may be revoked in writing at any time, except to the extent that action has already been taken in response to this authorization. I also release BC health Services from any liability or legal responsibility in connection with the release of the above information. I do not give permission for any other use or re-disclosure of this information.

I also accept the risk and consequence of faxing medical records.

Patient Signature Guardian Signature(if under 18) Witness Date

Step 4: Release for Sensitive Information

I understand that if my medical record contains information in reference to drugs and/or alcohol abuse, psychiatric, venereal disease, social service, Hepatitis B testing/treatment and/or sensitive information, **I agree to the release of this information, with my signature and date on the lines below.**

Patient Signature Date

Step 5: Release of HIV Information

In addition to the above signatures, if you want your HIV (AIDS) testing/treatment records released, **I agree to the release of this information, with my signature and date on the lines below.**

Patient Signature Date

Below is for BC Use Only

10/06

Date Received: _____ Date Sent: _____ Initial: _____ Mailed: _____ Fax: _____ Pick up: _____

