AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

University of Missouri-St. Louis
One University Blvd.
131 Millennium Student Center
St. Louis, MO 63121-4400
P: 314.516.5671
F: 314.516.5988

UMSL Health Services
Targeted Student Care

Patient Full Name:	Former Name:	Phone Number:
Student ID#:	Date of Birth:	

I hereby authorize my medical records to be released to/obtained by the University of Missouri-St. Louis Health Services as follows:

- ☐ History & Physical
- ☐ Laboratory
- ☐ Clinical Records
- ☐ Immunizations
- ☐ Psychiatric
- ☐ Other:

Purpose for this request:

Date(s) of Treatment:

I'd like my records released to/obtained from:

Recipient:

Street Address:

City, State & Zip:

Telephone No.:

Fax No.:

Method for release:

- ☐ I'll **PICK UP** my records at 131 MSC.
- ☐ Please **FAX** my records.
- ☐ Please **MAIL** my records.

I understand that I may revoke this authorization at any time except to the extent that prior action has been taken in reliance on this authorization. This authorization will expire ninety (90) days from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel or revoke this authorization, I must mail, fax, or bring a letter in person stating that I want to cancel this authorization. I understand that I need to mail, fax, or bring the letter to the location noted at the top of this page.

Patient/Requester Signature: Date:

Records were released as requested above by:

Signature of Health Services Staff: Date Released: