University of Bridgeport/UB Clinics
60 Lafayette Street
Bridgeport, CT 06604
Phone 203-576-4349 Fax 203-576-4776

Authorization to Obtain/ Release Medical Information

Patient Name: ____ **DOB:**________________

Address: ____

City: ______________________________________ **State:** ____________ **Zip:** _________________

Daytime Telephone: ____

I hereby authorize UB Clinics to: (*please check one*)

____ **Release information from Acupuncture, Chiropractic, or Naturopathic medical record to:**

____ **Obtain information from:**

Name: _____________________________ **Phone/ Fax:** _______________________________

Address: ____

City: ____________________________ **State:** _______________________ **Zip:** ____________

Information to be released or obtained as follows: (*please check one*)

All: ___________________

Limited to: ____

(specify)

Purpose of disclosure: (*please check one*)

At patients/guardians request: ____________________ **Changing physicians:** ________________

School: ____________________ **Legal:** ___________ **Consultation:** ___________ **Other:** ________

1. I understand that this authorization will expire one year after I have signed the form, or other timeframe as specified: ______________________________.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. 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 privacy regulations.
4. I understand that I am not required to sign this form in order to receive treatment or payment for my care.
5. I understand that there is a fee for a copy of my medical record.
6. I understand that the request could take at least two weeks to process.
7. I understand that information to be released or obtained may include mental health, substance abuse, or HIV/AIDS-related information, except as indicated below:

NO Mental Health _________ **NO Substance Abuse** __________ **NO HIV/AIDS**_______

____ ____________________

Signature of patient/parent/legal guardian/authorized person **Date**