University Medical Center

Updated as of 1/31/2018
Supersedes all prior versions

University Medical Center
Patient Request for Health Information

THIS AUTHORIZATION WIIL NOT BE ACCEPTED UNLESS ALL ITEMS ARE COMPLETED.

Patient Name (Please print): _____

Date of Birth: ____/_____/_____ Phone: _____

Name at the time of Treatment: _____

Address: _____

Phone: _____

____ Release Medical Records To:

Name: _____

Address _____

_____

Phone #: _____ Fax #: _____

_____ Release Medical Records From:

Name: _____ _____

Address: _____

_____

Phone#: _____ Fax #: _____

Please release from time period of: _____

What records do you want released? Please check what you would like released.

_____ Entire Record/All Office note: ____ Lab: ___Immunizations: ____X-ray: _____

Other: __ please specify: _____

How do you want your records delivered? Please check below:
Paper: ___email: ___ if by email please provide your email address: _____
Fax: _____ Other: ____ In-person Pick-up: _____

Please provide to Self: _____ Personal Representative: _____
*Examples of personal representative: 1)individuals with authority to act on behalf of an adult or emancipated minor in making decisions related to healthcare, 2) executors or administrators acting on behalf of a deceased individual or individual's estate, 3) someone involved in the patient's health care or payment
____Third Party:* Check this only if the patient or personal representative has requested release to a third party. Example/; personal attorney, relative

Relationship to Patient: _____

Signature of Patient: _____ Date: _____

Signature of Personal Representative: _____ Date: _____

Relationship to Patient: _____

Medical Records 850 Peter Bryce Blvd. Tuscaloosa, Al 35401 Phone: 205- 348-1252 Fax: 205-348-2402

There may be charges associated with processing a request and producing requested records.