GENERAL REQUEST FOR RELEASE OF MEDICAL RECORDS

To be used for release of information to the patient, whoever the patient designates release to, or to a provider of their choice; or to request the patient's records from another provider.

In order to release your/the patient's records, you must sign a request for release. This form must include the patient's name and date of birth. It is your responsibility to read this form in full and to ask any questions before the record is released. No phone call requests will be honored.

Designate Who You Want To Release Your Records:

University of Louisville (UofL) Release Your Records

The following information explains our policy for releasing protected health information:

- Medical records will be released only to the patient or to whoever the patient designates them to be released to.
- Law office/attorney medical records requests must have valid patient authorization with the request.
- Please be prepared to show ID when picking up records in person. This is for the protection of your personal health information.
- Patient's legal representatives must provide appropriate documentation to demonstrate their legal status.
- HIV, STD, substance abuse, and psychiatric records are not released without specific separate authorization.
- Please allow up to 30 days for records stored off site; however, UofL may take up to 60 days to process the request, if necessary.
- First copy provided free of charge.

Release Records to (provide information below): ☐ Patient's Designee ☐ Provider Office

Name ______________________ Phone ____________ Fax ____________

Address ____
Street City State Zip

Another Provider Release Your Records To UofL

Provider Name ______________________ Phone ____________ Fax ____________

Provider Address ____
Street City State Zip

Patient Information, Signature, and Records Being Released:

______________________________ ____________
Patient's Name (Please Print) Date of Birth

______________________________ ____________
Patient/Parent/Legal Guardian Signature Date

If Parent/Legal Guardian, Print Name ______________________

Records Being Released : Date Range From ____________ To ____________

☐ Entire Chart ☐ Labs ☐ Office Notes ☐ Other (Specify Below)

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Do Not Write Below This Line – For Office Use Only

*****NOTE**: Verify other party's fax number before sending fax*****

UofL Practice Site (optional) ______________________________

Phone ____________ Fax ____________

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