UNION PHYSICIAN SERVICES
AUTHORIZATION FOR RELEASE OF INFORMATION

UPS
UNION PHYSICIAN SERVICES

Patient's Name: _____ Social Security #: _____

Date of Birth: _____ Date of Treatment: _____

1. I authorize Name: _____

Address: _____

To: ☐ Release records to
☐ Obtain records from
☐ Exchange information with

Name: _____

Address: _____

This includes: Diagnosis, HIV testing, care and treatment of AIDS related condition, drug/alcohol abuse and/or psychiatric/mental conditions:

Requested Records to Release:

☐ DISCHARGE SUMMARY
☐ HISTORY AND PHYSICAL
☐ OPERATIVE REPORTS
☐ PATHOLOGY REPORTS
☐ RADIOLOGY REPORTS
☐ X-RAY FILM
☐ LABORATORY REPORTS
☐ CARDIOPULMONARY REPORTS
☐ PHYSICIAN'S ORDERS/PROGRESS NOTES
☐ CONSULTATION REPORTS
☐ OTHER: _____
☐ COMPLETE MEDICAL RECORD (do not check this unless entire record is required)

2. The above information is released for the following purpose and that purpose only. Any other use is forbidden:

_____ Insurance or other third party reimbursement
_____ Continuity of medical care
_____ Pending legal action
_____ Other (specify) _____

3. A copy of this authorization made by duplicating process shall be valid for all purposes as this original signed by me. I understand that the release form must be dated not more than sixty (60) days before the date on which it is submitted.

BY SIGNING BELOW I CERTIFY THERE IS NO COURT ORDER IN EFFECT WHICH LIMITS OR PROHIBITS MY ACCESS TO THESE RECORDS.

_____ _____ _____
(Signature) (Date) (Time)

Signed: Patient ☐ Spouse ☐ Guardian ☐ Other: _____

A legal document naming guardian or executor of estate must accompany authorization where applicable (proof of legal executor of estate of those patients expired, or legal proof of guardianship).