

This information is being disclosed for the following purposes:

- Legal Reasons
- Continued Care and Treatment
- Disability
- Other (please specify) _____
- Workman's Compensation
- Personal Use
- Insurance

I understand that I/my legal representative may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization or according to law. Written revocation must be sent to the person that I authorized to release my information.

This authorization will expire in 120 days unless otherwise specified (insert date or specific event):

_____.

I hereby certify that I have read the provision set forth in this authorization. I understand and agree to its terms.

Patient Signature _____ Date: ____/____/____

**** If you are signing as a legal representative for an individual, read and sign below****

I, _____, hereby certify and attest that I am duly authorized legal representative of _____ and that I have lawful authority regarding the use and or disclosure of Protected Health Information of such individual for the purposes set forth in this document.

Signature

Print Name

Date

YOU SHOULD RECEIVE A COPY OF THIS AUTHORIZATION FROM AFTER SIGNING.

Received By _____ Date Received ____/____/____

****Please note that UENTS reserves the right to allow 30 days for medical records requests to be completed.**