AUS | الجامعة الأميركية في الشارقة American University of Sharjah

Authorization Release

University Health Services

I authorize the following protected health information to be released from the medical record of:

LAST NAME (PLEASE PRINT) _____ FIRST NAME (PLEASE PRINT) _____ DATE OF BIRTH _____

EMAIL ADDRESS _____ ID NUMBER _____ MOBILE PHONE NUMBER _____

PHONE NUMBER _____ DATE _____

Release Records

- ❑ From University Health Services
- ❑ To AUS Record Release

PO Box 26666
Sharjah, UAE
Phone: 971-06-515 2760

Release Records

- ❑ To
- ❑ From

NAME/ORGANIZATION _____

ADDRESS _____

CITY _____ STATE _____ COUNTRY _____

PHONE _____ FAX _____

❑ Please call when my records are ready for pick-up	❑ Please mail my records	❑ Please Fax my records

I understand that the recipient of this information as identified above may not be covered under any privacy law. The documents being delivered are no longer under the privacy statement of the American University of Sharjah once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.

To Be Released:	**Date of Service/Provider:**	**To Be Released:**	**Date of Service/Provider:**
❑ Office Visits		❑ Immunizations	
❑ Urgent Care Visits		❑ Lab Work/Results	
❑ Radiology Reports		❑ Nurse Treatment	
❑ Psychologist		❑ Dietician	
❑ Entire Record		❑ Other	

Note: If specific dates to be released or a specific provider are not indicated, all records in marked category will be released.

Reason For Release of Information	**Name** (please print)	
❑ At the request of parent/guardian of the patient		
❑ At the request of the patient		
❑ Other		

SIGNATURE _____ DATE _____ RELATIONSHIP TO PATIENT _____

❑ I have verified the patient's identification

UHS STAFF SIGNATURE/POSITION _____ DATE _____

UHC STAFF ONLY

Date Released: _____ Released by: _____

Notes: _____

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