UNC GREENSBORO
Division of Student Affairs
Student Health Services

The University of North Carolina at Greensboro
Anna M. Gove Student Health Services
107 Gray Drive Greensboro, NC 27412-6170
Medical: Phone 336-334-5340 Fax 336-334-5343
Counseling/Psychiatric: Phone 336-334-5874 Fax 336-334-3900

UNCG Student Health Services is required by law to keep your information confidential. If you authorize the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name: Last_____ First_____ MI_____

Previous Name: _____ Telephone Number (____) ____-____

Date of Birth (mmddyy):_____ UNCG ID #: _____ Year Started UNCG _____

I authorize UNCG Student Health Services to: (check all that apply)

☐ **Release information to:** ☐ **Obtain my information from:** ☐ **Verbally communicate information with:**

Name/Organization:_____

Street Address:_____

Apartment #_____ City_____ State_____ Zip Code_____

Telephone Number (____) ____-____ Fax Number (____) ____-____

Please release or send the following information from my health record: (check all that apply)

☐ Complete Medical History
☐ Women's Health (notes, pap, lab)
☐ Lab Results
☐ X-ray Report / X-ray CD
☐ Physical Exam
☐ Immunizations
☐ Consultation Report
☐ Medical Treatment Summary
☐ Pharmacy Record
☐ Billing Record
☐ Other (please specify)
_____
☐ Counseling Treatment Summary
☐ Complete Counseling Record
☐ Psychiatric Treatment Summary
☐ Complete Psychiatric Record

Specify Date(s) of Service/Treatment: (all dates included unless otherwise indicated)_____

Limitation of this Authorization: (if nothing indicated, no limitations) _____

Purpose of Disclosure:

☐ Administration/Academic Coordination
☐ Coordination of Care/Treatment
☐ Guardian Communication
☐ Employment
☐ Insurance
☐ Other (please specify) _____
☐ Medical Care
☐ Personal

I understand this authorization applies to the items checked and is only valid through the date indicated on this form.
I understand that disclosure or release of information to anyone other than the named entities above require another authorization.
I understand information disclosed pursuant to this authorization may include HIV/AIDS, treatment for drugs/alcohol abuse, mental/behavioral health or psychiatric care.
I understand that I have the right to revoke this authorization at any time in writing to UNCG Student Health Services. The revocation will not apply to information already released/received in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim under my policy.
I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

I understand that once the authorization is received the processing time for all health records is within 7 business days.
I understand that a valid photo ID must be submitted with the completed request.

Unless otherwise revoked, this authorization expires on _____. If no date is indicated, the authorization will expire 12 months from the date signed.

Patient Signature:_____ **Date:**_____
Legal representative/Relationship:_____/_____ **Date:** _____

UNCG SHS Witness:_____ ☐ **Date:**_____ ☐ **Photo ID Received:**_____
Delivery Method to Patient: ☐ **Pick Up** ☐ **Mail via USPS**