

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)

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

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

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

Purpose of Disclosure:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Administration/Academic Coordination | <input type="checkbox"/> Employment | <input type="checkbox"/> Medical Care |
| <input type="checkbox"/> Coordination of Care/Treatment | <input type="checkbox"/> Insurance | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Guardian Communication | <input type="checkbox"/> Other (please specify) _____ | |

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 5 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