University of North Florida, Student Health Services

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Authorization for Use, Disclosure, and Release of Health Information

_____ _____ _____

Patient Name: Last First MI Date of Birth Student ID Number

I hereby authorize:
(Name and address of releasing facility)

_____

_____

_____

To Release Information to:
(Individual name, facility/organization and address)

_____

_____

_____

PURPOSE OF DISCLOSURE:

- ☐ Continuing Care
- ☐ Payment of Claim
- ☐ School
- ☐ Worker's Compensation
- ☐ Legal
- ☐ For Personal Use
- ☐ Other (specify):

All information regarding Alcohol and/or Drug Abuse or Behavioral Health will be released **unless you restrict** by initialing below:

Initial

_____ do not release Alcohol and/or Drug Abuse information.

_____ do not release Behavioral Health Information

INFORMATION TO BE RELEASED: Between Dates of: _____ to _____

☐ Progress Notes/Provider Notes	☐ Immunization Records	☐ Lab Reports/Results
☐ Diagnostic Test Reports	☐ Consultation Notes	☐ Allergy Records
☐ Prescriptions	☐ HIV related information	☐ STD information
☐ PAP Reports	☐ Depo-Provera Records	☐ GYN Records

☐ Entire Record (excluding special permission records if initialed in above box).

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand that this authorization is for a one time use only.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at anytime except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.
- I understand that SMS may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
- I understand that a photocopy or fax of this form is the same as the original.
- YOU MUST PROVIDE A PHOTO I.D. TO OBTAIN RECORDS

_____ _____

Patient Signature (**Photo I.D. Required**) Date

If I am signing as Authorized Representative of the patient, I am:

☐ **Parent of minor** ☐ **Court appointed guarding/conservator**

_____ _____

Signature of Authorized Person Relationship to Patient

_____ _____

Witness Date