University of North Florida, Student Health Services
1 UNF Drive, Bldg 39A, Jacksonville, Fl 32224 * Phone: (904) 620-2900 * Fax: (904) 620 2902

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)

Student Health Services
1 UNF Drive Bldg. 39A Room 2098
Jacksonville, FL 32224

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): _____

Special Permission Records

- ☐ Do Not Release Alcohol and/ or Substance Abuse
- ☐ Do Not Release Behavioral Health Information
- ☐ Do Not Release Health Information

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

- ☐ Entire Record (excluding any special permission records)
- ☐ Progress Notes/ Provider Notes
- ☐ Prescriptions
- ☐ Depo- Provera Records
- ☐ GYN Records
- ☐ Diagnostic/ Lab Test Reports
- ☐ Immunizations Records
- ☐ Allergy Injection Records
- ☐ Other (Specify): _____

Please release by: ☐ **MAIL** to address above or ☐ **EMAIL** _____

Notice for release by email: Email is not a secure form of communication. By checking the email option, I acknowledge the potential security risks and wish to proceed.

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand this authorization is for a one time 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 the information used or disposed pursuant to this authorization is no longer in the exclusive control of UNF and UNF is not liable for any subsequent disclosures by the recipient.
- I understand this consent for release of alcohol and/ or drug abuse information is subject to revocation at any time 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 Student Health Services 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 Guardian/ Conservator**

_____ _____
Signature of Authorized Person Relationship to Patient