

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Medical Records
126 Student Health Center, University Park, PA 16802
Telephone: (814) 863-1975 Fax: 814-865-6982

Student must read: I understand that my medical record may contain information (including medications) related to **alcohol/drug abuse and/or dependence, mental health/rehabilitation, HIV and/or AIDS, and/or sexual assault**. This information will be disclosed unless I specify that the information **not** be disclosed by **initialing** below:

____ Alcohol/Drug Abuse and/or Dependence ____ Mental Health/Rehabilitation ____ HIV and/or AIDS ____ Sexual Assault

Student must complete:

Name: _____ Date of Birth: _____
Address: _____ PSU ID# or SSN: _____
City, State, Zip: _____ Telephone Number: (____) _____

Student must complete:

I authorize University Health Services to (**select only one**) _____ DISCLOSE PHI TO: _____ OBTAIN PHI FROM:

Name/Organization: _____
Address: _____ Telephone: (____) _____
City/State/Zip: _____ *Fax: (____) _____
* (Emergency situations only)

Information To be Disclosed /Obtained (least one box must be checked)

- Immunizations Treatment Notes Laboratory/Pathology Reports Radiology Reports Physical Therapy Notes
 Other: _____

Information Disclosed or Obtained will fall within this date range; two dates are required. ____/____/____ through ____/____/____
(mm) (dd) (yr) (mm) (dd) (yr)

Purpose of this request (**Select only one**): Healthcare Payment of a claim Personal Other: _____

Student must read these two paragraphs:

I understand that I have a right to revoke this authorization at any time; if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management (HIM) Dept. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire _____. If I fail to specify an expiration date or event, this authorization will expire 90 days from the date on which it was signed. 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 also understand that the information disclosed according to this release may be redisclosed by the recipient and is no longer protected by HIPAA (Federal Regulations).

Student must sign and date this form:

Signature of patient or legal representative Date If signed by legal representative, relationship to patient

Signature of staff member assisting with form completion: _____ Date: _____

This publication is available in alternate media on request. Penn State is committed to affirmative action, equal opportunity, and diversity of its workforce. U.Ed. STA 03-323