PennState Student Affairs | University Health Services

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

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

Patient 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

Patient must complete:

Name: _____ **Date of Birth:** _____

Address: _____ **PSU ID# (If Applicable)** _____

City, State, Zip: _____ **Telephone Number: (_____)**_____

Patient 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 (at least one box must be checked)

☐ **Immunizations** ☐ **Treatment Notes** ☐ **Laboratory/Pathology Reports** ☐ **Diagnostic Testing 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:**_____

Patient 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).

Patient 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:** _____

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☐ **Patient Accepts Copy**
☐ **Patient Declines Copy**