PennState Student Affairs | University Health Services

Medical Records
128 Student Health Center
542 Eisenhower Rd
University Park, PA 16802
Phone: 814-865-4847 Fax: 814-865-6982

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

Legal Name (Last, First): _____ Date of Birth: _____

Address: _____ PSU ID# (if known): _____

City/State/Zip: _____ Phone#: _____

Former Name, if applicable: _____

I authorize Penn State University Health Services to (check one): ____Disclose my PHI to: ____Obtain my PHI from:

Name/Organization: _____

Address: _____ Phone#: ( ) _____

City/State/Zip: _____ Fax#: ( ) _____

The information to be used/disclosed/obtained (at least one box must be checked):

☐ Immunizations ☐ Treatment Notes ☐ Laboratory/Pathology Reports ☐ Diagnostic Testing Reports

☐ Radiology Reports ☐ Physical Therapy Notes ☐ Ambulance/Emergency Medical Service Reports

☐ Other (specify): _____

I understand that my medical record may contain information related to **substance use disorder treatment, mental health/rehabilitation treatment, HIV and/or AIDS, and/or sexual assault**. This information WILL BE disclosed/obtained unless I specify that the information not be disclosed by initialing below:

_____ substance use disorder treatment _____mental health/rehabilitation treatment _____HIV and/or AIDS _____sexual assault

The information to be used/disclosed/obtained will cover this time period: _____/_____/_____ through _____/_____/_____*
This date may not exceed the date of signature below

Purpose of this request (check one): ☐ Healthcare ☐ Personal ☐ Other (specify): _____

Revocation, redisclosure and expiration:
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 on _____. 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.

_____ _____ _____

Signature of patient (use legal name) or legal representative | Today's Date* | If signed by legal representative, relationship to the patient

Name of UHS staff member assisting with form completion: _____

_____ Patient accepted a copy _____ Patient declined a copy