

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

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

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