UNIVERSITY OF RICHMOND STUDENT HEALTH CENTER

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Instructions: The patient is required to complete this form in its entirety in order to be processed.

I authorize the following protected health information to be released from the medical record of:

LAST NAME (PLEASE PRINT) _____ FIRST NAMES (PLEASE PRINT) _____ DATE OF BIRTH _____

EMAIL ADDRESS _____ UR ID _____ TODAY'S DATE _____

PHONE NUMBER _____ DATE OF GRADUATION, IF APPLICABLE _____

PURPOSE FOR DISCLOSURE (Per HIPAA Requirements)

__Medical __Personal __Academic __Insurance/Billing __Legal __Other (must specify):_____

RELEASE RECORDS ____FROM ____TO

University of Richmond-Student Health Center

Special Programs Bldg, 490 Westhampton Way,

University of Richmond, VA 23173

Phone: 804-289-8064 Fax: 804-287-6466

RELEASE RECORDS ____FROM ____TO

Name/Organization _____

Address _____ City, State, Zip Code _____

Phone # _____ Fax # _____

Release of records by: ___Fax___Pick up at Health Center___Verbal ___Mail **Approximate dates of service:_____**

RECORDS TO BE RELEASED (Per HIPAA Requirements)

__Immunization Records __Lab Reports __Clinic Notes __Diagnostic Reports ___Other_____

- I understand that I may revoke this Authorization in writing at any time and will be effective when delivered to the health center, but will not apply to information that has already been released in response to this Authorization.
- I understand that refusal to sign this authorization will not in any way affect my treatment.
- As the person signing this authorization, I understand that I am giving my permission to use or disclose my confidential health records as indicated above. **The records may contain information from other providers, confidential HIV/AIDS related information, confidential communicable disease information, information related to drug/alcohol abuse/treatment and /or psychiatric mental health, unless specified here:_____.**
- I have been informed and understand that information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law.
- **This authorization will be valid for: (check one) _____This request only. ____One (1) year from date of signature.**

I have read and understand the information in this Authorization form.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN, IF UNDER THE AGE OF 18 DATE

_____

RELATIONSHIP TO PATIENT

NOTICE TO RECIPIENT OF RECORDS: The attached medical information is protected by federal privacy laws. You may not make further disclosures of the information without consent of the patient. In addition, you may use the information only for the purpose(s) for which the disclosure was made.

For Office Use Only:

Information released:_____Date:_____

Patient Identification Verified ____ ROI Logged____ Number of Pages Copied_____

Initials of Processor_____ Mailed ____ Faxed_____ Picked Up_____

Original: Medical Record Copy: Patient