AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

UNIVERSITY OF ALASKA FAIRBANKS
Student Health and Counseling Center

Student Name: _____
Phone Number: _____ **Date of Birth:** _____ **UAF ID#:** _____
Mailing Address: _____
Today's Date:_____

I HEREBY AUTHORIZE THE DISCLOSURE AND USE OF MY HEALTH INFORMATION: [CHECK AS APPROPRIATE]

○ **From** ○ **To** o **Both (Two-way)**
UAF Student Health and Counseling Center
612 N. Chandalar Drive
Fairbanks AK 99775
Phone: 907-474-7043
Fax: 907-474-5777

○ **From** ○ **To** o **Both (Two-way)**
Name: _____
Street Address: _____
City, State, Zip: _____
_____
Phone: _____
Fax:_____

DATES OF RECORDS/INFORMATION TO BE RELEASED
From: _____ To: _____ or All:_____

TYPES OF RECORDS/INFORMATION [Check as appropriate]
○ All medical records ○ Immunization record(s) ○ Lab result(s) o Psychological testing reports
○ X-ray or other diagnostic test reports ○ Other (please specify):_____
The following items must be initialed by you if you desire these records to be released:
Sexually transmitted diseases:_____ Genetic testing: _____
Substance or alcohol use/abuse: _____ HIV/AIDS:_____
Counseling visit notes (psychotherapy notes-release *may require consult with counselor*):_____

If our records include records or information from another health care provider or entity, that information:
[Check one] ○ should or ○ should not be released under this Authorization.

METHOD OF DISCLOSURE __ Mail __ Fax __In person __Verbal

PURPOSE OF DISCLOSURE (optional):
__Personal Use __Health care __Legal __Parent/Guardian __Insurance __Other

EXPIRATION OF AUTHORIZATION
This authorization will be in effect for **one year** unless otherwise noted here:_____

Re-disclosure: I understand that when the information is disclosed pursuant to this Authorization to someone who is not required to comply with the federal or state privacy protection requirements, it may be subject to re-disclosure by the recipient and may no longer be protected.
Revocation: I understand that I may revoke this Authorization at any time by writing to the address above. A request to revoke my authorization will not apply to the extent that SHCC has taken action in reliance upon this authorization.
Conditioning of Eligibility: SHCC will not condition treatment, payment, and enrollment or benefit eligibility on my signing this document.

_____ _____ _____
Signature of student or other authorized person | Date | Printed name of other authorized person (if used)

The Student Health and Counseling Center reserves the right to authenticate patient signature on forms received by fax or mail prior to the release of requested information.

FOR INTERNAL OFFICE USE ONLY

Records released as instructed: By_____ Date _____