

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION



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 Both (Two-way) To Both (Two-way)

UAF Student Health and Counseling Center

1788 Yukon Drive
Fairbanks AK 99775
Phone: 907-474-7043
Fax: 907-474-5777

Name: **UAF Residence Life and UAF Risk Management**

Street Address: **UAF Campus**
City, State, Zip: _____
Phone: _____
Fax: _____

DATES OF RECORDS/INFORMATION TO BE RELEASED All: _____

TYPE OF RECORDS/INFORMATION: COVID-19 test results

METHOD OF DISCLOSURE: Fax _____ Verbal _____ Uploaded to Housing Website _____ Secure Email _____

PURPOSE OF DISCLOSURE: Health care

EXPIRATION OF AUTHORIZATION:
This authorization will expire in **one year**

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 _____