Student Health and Counseling Center

P.O. Box 755580, 1788 Yukon Drive | Fairbanks, AK 99775-5580 | 907-474-7043, telephone 907-474-5777, fax | www.uaf.edu/chc

UAF STUDENT HEALTH AND COUNSELING CENTER AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Date of request *

Month Day Year

Student name *

First Name Last Name

Student date of birth *

Month Day Year

Student UA identification number *

xxxxxxx

Student address *

Street Address

Street Address Line 2

Student telephone number *

xxx-xxx-xxxx

I HEREBY AUTHORIZE THE DISCLOSURE AND USE OF MY HEALTH INFORAMTION (check as appropriate): *

- From
- To
- Both, To and From

UAF Student Health and Counseling Center

1788 Yukon Drive, P.O. Box 755580 Fairbanks, AK 99775

Phone: (907)474-7043, Fax: (907)474-5777

AND *

- To
- From
- Both, To and From

Name *

Type the name of the entity you wish to release information to/from

Address *

Entity's Street Address

Entity's Street Address Line 2

Telephone number *

Entity's telephone number xxx-xxx-xxxx

Fax number *

Entity's fax number xxx-xxx-xxxx

DATES OF RECORDS/INFORMATION TO BE RELEASED:

From

Month Day Year

To

Month Day Year

Check this box if you want records from ALL dates of service to be released regardless of dates.

- [ ] Please include records from ALL dates of service.

Please select the types of records/information you want disclosed. Check only those selections which are necessary. *

- [ ] All health records (medical and counseling)
- [ ] Medical records
- [ ] Immunization records
- [ ] Lab results
- [ ] X-ray or other medical diagnostic test reports
- [ ] Counseling records
- [ ] Counseling services treatment summary
- [ ] UAF Disability Services Verification form or letter
- [ ] Extenuating circumstances letter

☐ _____

THE FOLLOWING ITEMS MUST BE INITIALED BY YOU IF YOU DESIRE THESE RECORDS TO BE RELEASED:

If UAF SHCC records include records or information from another health care provider or entity, that information: *

○ should be released under this authorization

○ should NOT be release under this authorization

How would you like this information to be disclosed? *

☐ Mail
☐ Fax
☐ In person (you will physically pick up the records from UAF SHCC)
☐ Verbal

What is the purpose of this disclosure? *

☐ Personal use
☐ Health care
☐ Legal
☐ Parent/Guardian
☐ Insurance
☐ Care Coordination
☐ _____

EXPIRATION OF AUTHORIZATION

This authorization will expire in ONE YEAR unless you select another date below:

Month Day 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.

If you are under age 18, your legal parent/guardian must sign this form.

Name of person signing this form *

First Name Last Name

Please indicate the choice below that describes your role in signing this form. *

I am age 18 or older and have legal authority to sign this form on my own behalf.

I attest that I am the legal guardian of the student identified on this form and have the authority to consent for their release of health records.

Date of Signature *

Month Day Year

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

FOR INTERNAL OFFICE USE ONLY

Records released as instructed by:

First Name Last Name

Date

Month Day Year

UAF is an AA/EO employer and educational institution and prohibits illegal discrimination against any individual: www.alaska.edu/nondiscrimination/.