UCF | Student Health Services

Health Information Management Department
4098 Libra Drive, Orlando, FL 32816-3333
Tel (407) 823-2091, Fax (407) 823-3359

Things to Remember

If you are requesting information to be sent **FROM** UCF SHS to yourself, or an outside provider or party, please fill-in the information below in the **"Entity Releasing Information"** section.

Name: UCF Student Health Services
Address: 4098 Libra Drive, Orlando, FL 32816
Phone: (407) 823-2091 | Fax: (407) 823-3359

If you are requesting information to be sent **TO** UCF SHS from an outside provider, please fill-in the information above, in the **"Entity Receiving Information"** section.

If the information you are requesting may contain any mention of Alcohol Abuse, Sexual Assault, Drug Abuse, STDs, HIV/AIDS, or Mental Health, please **INITIAL** in the areas identified below.

I understand that this information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by initialing below, I am specifically authorizing the release of information relating to:

____ Alcohol Abuse	____ Sexual Assault Records	____ Drug Abuse
____ STD	____ HIV and/or AIDS	____ Psychiatric Records

The confidentiality of this record is required under U.S. Public Law 104 and Florida State Law. This material shall not be transmitted to anyone without written consent or authorization as provided in these statues.

If you are completing this form **OUTSIDE** of UCF SHS, please ensure the form is **NOTARIZED** in the **WITNESS** section on Page 2.

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____ UCF ID#: _____

_____ _____

Signature of Parent or legal Guardian (when applicable) Date

_____ _____

Witness Name & Signature Date

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Authorization to Release Protected Health Information

☐ **Entire Medical Record:** O **All** / O Specific date: _____ ☐ **GYN Records:** O All / O Specific date: _____
☐ **Dental Record/Images:** O All / O Specific date: _____ ☐ **Lab Result**: List test(s) or date(s): _____
☐ **Radiologist Interpretation/Report:**_____ ☐ **Copy of Medical Images**: _____
☐ **Immunization Records:** O All or O Specific Immunization _____
☐ **Other:** _____

I understand that this information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by **initialing** below, I am specifically authorizing the release of information relating to:

____ Alcohol Abuse ____ Sexual Assault Records ____ Drug Abuse

____ STD ____ HIV and/or AIDS ____ Psychiatric Records

The confidentiality of these records is required under U.S. Public Law 104, 42 CFR Part 2, and Florida State Law. This material shall not be transmitted or re-disclosed to anyone without written consent or authorization as provided in these statutes. **Please note: Any records released will include a current medication list that may be related to the above information.**

Format: ☐ **Pick up** ☐ **Mail** ☐ **Fax** ☐ **Consent to Discuss**
☐ **Paper** ☐ **CD** ☐ **Flash Drive** ☐ **Email**

Entity Releasing Information

Name: _____

Address: _____

Phone: _____ Fax_____

Entity Receiving Information

Name: _____

Address: _____

Phone: _____ Fax: _____

Email Address:_____

Purpose of Disclosure: Continuity of Care _____ Other_____

- I understand if the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy laws and may be redisclosed.
- I understand that I may ask and get a copy of this authorization after I sign it.
- UCF Student Health Services may not deny treatment, payment, enrollment or eligibility for benefits based on whether or not I sign this authorization.
- **I understand that this authorization will expire 90 days from date signed unless another date is specified for continuous exchange of information. Expiration Date: _____**
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any affect on any actions UCF Student Health Services took before they received the revocation.

********IF NOT SIGNED IN PERSON FORM MUST BE NOTARIZED BELOW IN THE WITNESS SECTION********

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____ UCF ID# _____

_____ _____
Signature of Parent or legal Guardian (when applicable) Date

_____ _____
Witness Name & Signature Date

Revocation of Authorization

I, _____, would like to revoke this authorization as of: _____

Signature to Cancel: _____

*******CONFIDENTIALITY NOTICE*******

The documents accompanying this telecopy transmission contain confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you received this telecopy in error, please notify the sender immediately to arrange for return of these documents.

Faxed By: _____ **Mailed By:** _____ **E-mailed By:** _____ **Hand Carried By:** _____ **Date:** _____

Revised: 08/18/2020