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 statutes.

If you are completing this form OUTSIDE of UCF SHS, please ensure the form is NOTARIZED in the WITNESS section on Page 2.
Authorization to Release Protected Health Information

- Entire Medical Record: □ All / □ Specific date: _____________
- Dental Record/Images: □ All / □ Specific date: _____________
- GYN Records: □ All / □ Specific date: _____________
- Radiologist Interpretation/Report: _____________
- Lab Result: List test(s) or date(s): _____________
- Immunization Records: □ All / □ Specific Immunization: _____________
- Copy of Medical Images: _____________
- Other: _____________

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

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.

<table>
<thead>
<tr>
<th>Entity Releasing Information</th>
<th>Entity Receiving Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: ________________________</td>
<td>Name: ________________________</td>
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<td>Address: _____________________</td>
<td>Address: _____________________</td>
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<tr>
<td>Email: ______________________</td>
<td>Email: ______________________</td>
</tr>
</tbody>
</table>

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: 05/25/2022