



Student Health Services

Health Information Management Department
4098 Libra Drive, Orlando, FL 32816-3333
Tel 407.823.2701 Opt. 3 | Fax 407.823.3359

Authorization to Release Protected Health Information

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

- 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.**

Entity Releasing Information

Entity Receiving Information

Name: _____

Name: _____

Address: _____

Address: _____

Phone: _____ Fax: _____

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: _____