UCF | 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

Date Range of Records Request: _____ to _____ -**OR**- ☐ **Complete Record** (All Records All Dates)

Type of Records: ☐ Progress Notes ☐ Labs ☐ Medication List ☐ Radiology report/images ☐ Billing ☐ Other (Please specify)_____

Method of Delivery: ☐ Portal ☐ E-Mail ☐ Fax (Medical Facilities only) ☐ Mail ☐ Pick-up

Purpose of Disclosure: ☐ Continuity of Care Other_____

Selecting *Consent to Discuss* allows UCF SHS to discuss your medical care, treatment, billing, services, etc. to whomever is designated on the form. The Security Question can be anything as simple as "What is the family dog's name?" Choose a question and answer that only you and the designated individual would know.

☐ **Consent to Discuss (security question)** _____ **Answer:** _____

Requested records will ***NOT*** include the following information unless initialed

_____ HIV/AIDS _____ Psychiatric Records _____ Drug and/or Alcohol Abuse _____ STD _____ Sexual Assault 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:	Email:

- 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 re-disclosed.
- 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 I may revoke this authorization at any me by notifying the providing organization in writing, but if I do, it won't have any effect on any actions UCF Student Health Services took before they received the revocation.
- **I understand that this authorization will expire 1 year from date signed unless another date is specified for continuous exchange of information. Expiration Date:**

Print Name: Date:

Patient Signature: Date of Birth: UCF ID#:

Signature of Parent or legal Guardian: Date:

Witness Name & Signature: Date:

Revocation of Authorization

If you would like to revoke your authorization at any time please email **medrecords@ucf.edu** requesting revocation of authorization. Request must be from your UCF email.

*******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.

rev. date: 8/15/2023