UCF Health | Student Health Services

Health Information and Management Department
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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
(Part 2 Substance Use Disorder Services Records ONLY)

I **authorize** *UCF Health SHS Substance Use Disorder Services (SUDS)* to

RECEIVE FROM ☐ **DISCLOSE TO** ☐ **DISCUSS WITH** ☐

the following **INDIVIDUAL / ENTITY:**

Name of Individual / Entity

Address:

Phone: Fax: Email:

the following SUDS records (please specify)*:*

METHOD OF DELIVERY: Email ☐ Fax ☐ Portal ☐ Mail ☐ Pick-up ☐

PURPOSE: Continuity of care ☐ Legal ☐ Other

EFFECT:

- I understand my substance use disorder treatment records are protected under federal law (42 CFR Part 2 and HIPAA) and applicable state law, and can only be used or disclosed with my written consent, except as allowed by law.
- I understand that if HIPAA covered entities and business associates receive these records for treatment, payment, and health care operations, the records may be redisclosed in accordance with HIPAA, except for uses or disclosures for civil, criminal, administrative, or legislative proceedings against me.
- UCF Health Student Health Services may not deny treatment, payment, enrollment, or eligibility for benefits based on whether or not I sign this authorization.
- I may request a copy of this authorization after signing, it has been explained in a language I understand, and I acknowledge that records disclosed may no longer be protected by Part 2.
- I may revoke this authorization in writing at any time; prior to receipt of revocation, actions already taken by UCF Health Student Health Services cannot be reversed.

EXPIRATION DATE: Unless I revoke my consent, this authorization will take effect immediately and expire (check one only)

End of SUDS Part 2 Program treatment ☐ **- OR -** **Expiration Date**

Print Name:		Date:
Patient's Signature:	Date of Birth:	UCF ID:
Signature of Parent/Legal Guardian:		Date:
Witness Name & Signature:		Date:

REVOCATION OF AUTHORIZATION:

I have the right to revoke this authorization in writing at any time, except for any actions already taken before revocation was received. I understand that I may revoke this consent by emailing **medrecords@ucf.edu** and stating, "revocation of authorization"; the request must be sent from my UCF email.

FOR OFFICE USE ONLY: