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FLORIDA ATLANTIC UNIVERSITY
MEDICAL GROUP

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name:_____ Date of Birth:_____
(Please Print)

Address: _____ Telephone:_____

Verification of identity: ☐ Driver's License/State ID ☐ Personally known ☐ Other

I hereby authorize Florida Atlantic University Student Health Services to (choose one):

☐ use or disclose my protected health information as indicated below to:
☐ obtain my protected health information from:

Name: _____ ☐ Will pick-up in person
☐ Please mail to address noted
☐ Please fax to # _____

Address: _____

For purposes of (describe purpose) and time period (dates):_____

Records requested:
☐ Immunization records
☐ Partial record, as specified (include date of visit if applicable): _____
_____
☐ Other (describe record and/or information): _____
_____

I understand that this health information may include sensitive information. By signing this area below, I am specifically authorizing the release of information relating to:

_____ (initial here) HIV/AIDS and sexually transmitted disease information
_____ (initial here) Alcohol and substance abuse information
_____ (initial here) Mental health information and psychotherapy notes

Signature: _____ Date: _____

I have read and understand the following statements of my rights:

- This authorization will remain in effect for one (1) year or until I revoke it in writing. I understand that I may revoke this authorization at any time by providing written notice. However, the revocation will not have any effect on any actions taken before its receipt and processing.
- I may see and copy the information described on this form, if requested.
- I am not required to sign this form to receive my health care benefits, and my refusal to sign this authorization will not affect my treatment, payment, enrollment, or eligibility for benefits or the quality of care that I will receive.
- I received the Notice of Privacy Practices and had the opportunity to ask questions about it, as well as about the use and disclosure of my health information before signing. The Notice of Privacy Practices is subject to change at any time.
- I understand that information released pursuant to this authorization may no longer be protected by state law or the federal health privacy law and could be re-disclosed by the person or entity that receives it.
- I am aware that the charge for copying records is $1.00 per page for the first 25 pages and $0.25 for each additional page thereafter. Please allow up to five (5) business days for copies to be made. Fees are waived when health information is released to a health care provider for treatment purposes.
- A copy of this authorization is as valid as the original and is subject to its terms and conditions.

Authorization and Signature

I hereby authorize the use of disclosure of my individually identifiable health information as described herein. I understand that this Authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this Authorization. I further understand that if the organization authorized to receive the information is not a health care provider, the released information could potentially be re-disclosed any may no longer be protected by federal privacy regulations. Therefore, I release Florida Atlantic University from all liability arising from this disclosure of my health information.

Printed Name:_____

Signature:_____ Date:_____

Relationship to Patient:_____

For Office Use Only:	
Date picked up/mailed/faxed:	Staff Initial