



THE FLORIDA STATE UNIVERSITY

## UNIVERSITY HEALTH SERVICES

HEALTH & WELLNESS CENTER

All Authorizations for Use and Disclosure of Personal Health Information Forms must be completed and submitted to the Health Information Management Office at:

University Health Services  
Health Information Management Office  
960 Learning Way  
P.O. Box 3064178  
Tallahassee, FL 32306-4178  
Ph. (850) 644-5523; Fax: (850) 644-2737

The form must be complete to include:

- **I Request and Authorize:** The name or other specific identification of the person who is authorized to make the requested use or disclosure to include date of birth, address and phone number.
- **To Release my Medical Information to:** The name or other identification of the person to whom University Health Services may make the disclosure or use (Note: Please include address, phone and or fax number of the recipient).
- **Date Range:** A date range in the space provided otherwise only the most recent edition/form will be sent unless dates of service are specified
- **Items to be Disclosed:** A description of the information to be used or disclosed that is specific and meaningful (Note: Please check "Other" and write in a description of the information to be disclosed if the check boxes do not fit your needs).
- **Purpose of Disclosure:** A description of the purpose of the requested use or disclosure. Please check "Other" and write in the purpose if the check boxes provided do not meet your need.)
- **Expiration Date:** An expiration date of the disclosure. (Note: if expiration date is left blank the authorization will expire in one (1) year)
- **Signature information:** Signature of the requesting individual and date. If the authorization is signed by a personal representative, a description of that authority to act must be provided.

If any part of the above requirements is not included in the request your request will be denied and a written response regarding the reason for denial will be provided.

Should your request be denied please resubmit your request with the required information and your request will be completed within 7- 10 business days. A minimum of 24 hours is required to process the request except in situations of medical emergency.

**Please contact the Health Information Management Office at 850-644-5523 if you have any questions regarding the Authorizations for Release and Disclosure of Personal Health Information.**



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**University Health Services**  
 Health Information Management  
 960 Learning Way  
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OFFICE USE ONLY	
UHS ID # _____	FAX _____
ID CHECKED _____	MAIL _____
COMPLETED _____	PICK UP _____
EMPLOYEE _____	PAID _____

**Authorization for the Use, Disclosure and Receipt of Protected Health Information**

I request and authorize:

To release my medical information to:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Specific Medical Records Requested** – PLEASE INDICATE DATES OF SERVICE \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_.  
 (Note: Only the most recent edition/form will be sent unless dates of service are specified):

Please check the boxes adjacent to the items for which you are requesting disclosure.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Consultation Reports                | <input type="checkbox"/> Medication List                           | <input type="checkbox"/> Diagnostic Tests (Specify) _____ |
| <input type="checkbox"/> General Health Records <sup>1</sup> | <input type="checkbox"/> Psychiatry Clinic <sup>2</sup>            | <input type="checkbox"/> Other _____                      |
| <input type="checkbox"/> Immunization Records                | <input type="checkbox"/> Physicals (General, Athletic, etc.) _____ |   |
| <input type="checkbox"/> Laboratory Reports                  | <input type="checkbox"/> Problem List                              |   |

- I understand that the information in my general health records may include information relating to: Drug/Alcohol Abuse, STI/STDs, HIV/AIDS, Behavioral or Mental Health and Genetics.
- I understand that a summary of the Psychiatry Clinic records may be provided in lieu of complete Psychiatry records at the discretion of the Psychiatry Clinic clinician.

Please check the boxes adjacent to the reasons for disclosure.

- |   |   |
|---|---|
| <input type="checkbox"/> Continued Medical Care                               | <input type="checkbox"/> Personal Reasons |
| <input type="checkbox"/> Changing PCP & Discontinuing Care at this Office     | <input type="checkbox"/> Insurance        |
| <input type="checkbox"/> Leaving Town & Transferring Records to New Physician | <input type="checkbox"/> Attorney         |
| <input type="checkbox"/> Other: _____   |   |

- I understand that once information is disclosed, the information is subject to re-disclosure and may no longer be protected by federal privacy regulations.
- I understand that I have a right to revoke this authorization at any time except in the case that action has already been taken in regards to the request for authorization. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand the revocation will not apply to my health plan when the law provides my plan with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one (1) year from the date signed below.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment. I understand I may inspect or copy the information used or disclosed as provided in CFR 164.524. If I have questions about disclosure of my health information I can contact the Health Information Management Department Supervisor or Privacy Officer; I may also refer to the Notice of Privacy Practices provided to me at my initial visit at University Health Services or review it on University Health Services website at [www.uhs.fsu.edu](http://www.uhs.fsu.edu).

**Expiration Date:** \_\_\_\_\_  
 (If left blank, authorization will expire in one (1) year from the date signed below)

Name _____	Birthdate ____/____/____	Phone (____) _____ - _____
Address _____		
Signature of Patient or Legal Representative _____		
Relationship _____	Date: ____/____/____	

**Please Note:** This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to who it pertains or as permitted by state law (FL395.017, 455.241 and 394.459) and federal law 42 CFR, part II.

**Prohibition on re-disclosure of information pertaining to alcohol and drug abuse records:** This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.