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 six (6) months )

- **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.

There is no charge when UHS records are sent to or received from another licensed medical provider; beyond this service, UHS reserves the right to charge a fee for copying of records under CFR 45 Section 164.524. There is a charge of $1.00 per page for the first 25 pages and $0.25 per page thereafter for release of records that are not being provided to another licensed medical provider.

Payment must be received for records not provided to another licensed medical provider before the records will be released.

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.