THE FLORIDA STATE UNIVERSITY
UNIVERSITY HEALTH SERVICES
HEALTH & WELLNESS CENTER

University Health Services, Florida State University
960 Learning Way
Tallahassee, FL 32306-4178
(850) 644-3608
Fax: (850) 644-8958

Patient Disclosure Authorization

Student's Name (Printed)_____ _____ _____
Last First MI FSUSN / emplID Date of Birth

Emergency Contact Name _____ Relationship to Patient _____

Address _____ Phone (_____) _____

Do you want your treatment at University Health Services (UHS) discussed with this person? Yes_____ No_____

The staff members of UHS consider all patient information confidential. Please list all individuals with whom we may discuss your medical condition, test results, and/or treatment plan.

YOU MAY DISCUSS MY TREATMENT AT UHS WITH:

Note: Accepted relationship include immediate family members such as, mother, father, spouse, and children. The Health Center will not honor disclosure for discussion of medical conditions, test results, and/or treatment plans to departments on campus or relationships other than those stated without proper medical release forms on file.

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____

YOUR SIGNATURE BELOW ACKNOWLEDGES THE FOLLOWING:

1. I understand and acknowledge by signing this document that I give University Health Services permission to file a claim to my health insurance carrier for the purpose of payment for services I have received at UHS. I further understand and agree that UHS may not be a contracted provider with my individual health insurance plan and that I may be responsible for any unpaid balance, or services not covered by my insurance plan. I understand that it is my responsibility to know what coverage I have under my individual plan. I give UHS permission to place these unpaid balances on my account with Student Financial Services. I am aware that any unpaid balance on my account with Student Financial Services will generate a "hold" being placed on my registration and that I may be assessed service fees on balances not paid by the due date assigned by Student Financial Services.

2. RELEASE OF INFORMATION: I understand that my healthcare information may be exchanged verbally among health care providers of University Health Services (UHS) and University Counseling Center (UCC) for continuity of care purposes. UHS and UCC will follow state and federal laws, including HIPAA & FERPA, when protecting the release of sensitive information, which includes medical, psychiatric, social or psychological records including drug and alcohol abuse or addiction data, or HIV/STD information.

   I understand, I may opt-out (decline) participating in this exchange of information at any time. I understand that I have the right to revoke this authorization, except to the extent action has already been taken by UHS and/or UCC. I further understand that this does not authorize release of medical or mental health record copies, which requires a separate written authorization by me.

3. I understand I have a right to revoke this authorization at any time, except for cases where information has already been disclosed to those listed above. I understand that if I revoke this authorization, I must do so in writing by completing a new Patient Disclosure Authorization Form. Unless otherwise revoked, this authorization will remain on file in my electronic health record.

Student Signature _____ Date _____