Health Information Management Department
4098 Libra Drive, Orlando, FL 32816-3333
Tel (407) 823-2091, Fax (407) 823-3359

Authorization to Release Protected Health Information

☐ **Entire Medical Record:** O **All /** O Specific date: _____________ ☐ **GYN Records:** O All / O Specific date: _______________
☐ **Dental Record/Images:** O All / O Specific date: ______________ ☐ **Lab Result**: List test(s) or date(s): ______________________
☐ **Radiologist Interpretation/Report:**______________________ ☐ **Copy of Medical Images**: ___________________________
☐ **Immunization Records:** O All or O Specific Immunization ____
☐ **Other:** ____

I understand that this information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by initialing below, I am specifically authorizing the release of information relating to:

____ Alcohol Abuse ____ Sexual Assault Records ____ Drug Abuse

____ STD ____ HIV and/or AIDS ____ Psychiatric Records

The confidentiality of this record is required under U.S. Public Law 104 and Florida State Law. This material shall not be transmitted to anyone without written consent or authorization as provided in these statues.

Format: ☐ **Pick up** ☐ **Mail** ☐ **Fax** ☐ **Consent to Discuss**
☐ **Paper** ☐ **CD** ☐ **Flash Drive** ☐ **Email**

Entity Releasing Information

Name: ____

Address: ____

Phone: ______________________ Fax_______________

Entity Receiving Information

Name: ____

Address: ____

Phone: _______________ Fax: ____________________

Email Address:___________________________________

Purpose of Disclosure: Continuity of Care _____ Other____

- I understand if the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy laws and may be redisclosed.
- I understand that I may ask and get a copy of this authorization after I sign it.
- UCF Student Health Services may not deny treatment, payment, enrollment or eligibility for benefits based on whether or not I sign this authorization.
- **I understand that this authorization will expire 90 days from date signed unless another date is specified for continuous exchange of information. Expiration Date:** _____________
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any affect on any actions UCF Student Health Services took before they received the revocation.

********IF NOT SIGNED IN PERSON FORM MUST BE NOTARIZED BELOW IN THE WITNESS SECTION********

Patient Signature: ___________________________________ Date: ____________________________

Print Name: _______________________________ Date of Birth: __________ UCF ID# _________________________

____ _________________________________
Signature of Parent or legal Guardian (when applicable) Date

____ _________________________________
Witness Name & Signature Date

Revocation of Authorization

I, ____**, would like to revoke this authorization as of:** _______________

Signature to Cancel: _________________________________

*******CONFIDENTIALITY NOTICE*******

The documents accompanying this telecopy transmission contain confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you received this telecopy in error, please notify the sender immediately to arrange for return of these documents.

Faxed By: ___________ **Mailed By:** ___________ **E-mailed By:** __________ **Hand Carried By:** ___________ **Date:** ___________

Revised: 01/30/2016