Philadelphia University Student Health Services (PUSHS)
Patient Authorization to Release Protected Health Information (PHI)

Name: Date of Birth:

SID#: College Entry Year: Phone #: ( )

Date of Request: **Date Needed:**
This authorization shall be in effect from _____ until _____.

☐ I HEREBY AUTHORIZE THE DISCLOSURE AND USE OF MY HEALTH INFORMATION: (Check as appropriate.)

☐ **To** ☐ **From**

Name of Person, Provider or Facility

Address

City, State, Zip Code

Phone #/Fax # (include area code)

PURPOSE FOR THIS REQUEST: (Check one.) ☐ Healthcare ☐ Insurance coverage ☐ Personal ☐ Other

METHOD OF DISCLOSURE: Please release my records/information via: (Check as appropriate.)

☐ Mail ☐ Fax ☐ In person pick-up by patient ☐ Verbal

Please Note: While Philadelphia University Student Health Services will fax your PHI to the number you provide, Philadelphia University Student Health Services cannot control who at the fax recipient's location may have access to your information. By opting for your information to be released by fax, you acknowledge that faxing of your records may compromise your privacy.

TYPE OF RECORDS REQUESTED: (Check one.)

☐ Immunization Record ☐ Most recent STD results (excludes HIV results)

☐ Most recent HIV results ☐ Most Recent PAP smear results

☐ Other (please specify)

☐ All medical records related to a specific illness or injury**.**

☐ Specify illness/injury ☐ Date(s) of treatment

☐ Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)

Specific information (Check one or more, as applicable.)

☐ Procedure report ☐ History & physical ☐ Physical Therapy ☐ Laboratory test results

☐ X-ray reports ☐ Other

My initials below authorize inclusion of the following types of sensitive information pertaining to:

- Drug/Alcohol Use/Abuse:
- Genetic Testing:
- Pregnancy/Maternity:
- HIV/AIDS:
- Mental Health:
- Eating Disorders:
- Abortion:
- Sexually Transmitted or other reportable diseases:
- Abuse* (Sexual/Physical/Mental):

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If the information includes records or information from another health care provider or entity, that information:
(Check one.) ☐ should or ☐ should not be released under this Authorization.

Please Note: This Authorization applies ONLY to the information indicated above, and information will be sent ONLY to the above address or fax number. Additional information or disclosure to another person or entity or another address or fax will require another Authorization.

PATIENT ACKNOWLEDGEMENT-PLEASE READ CAREFULLY

Re-disclosure: I understand that when the information is disclosed pursuant to this Authorization to someone who is not required to comply with the federal or state privacy protection requirements, my information may be subject to re-disclosure by the recipient and may no longer be protected.

Revocation: I further understand that I retain the right to revoke this Authorization at any time, if I do so in the manner set forth below. I understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my PHI have already acted in reliance on this Authorization.

In order for my revocation to be effective, it must be in writing. The revocation must include:

- The patient's name, address and identification number, if applicable
- Sufficient information to identity this Authorization including date and recipient of PHI
- The patient's desire to revoke this Authorization
- The intended date of the revocation, if later than the receipt of the revocation, and
- The patient's signature

ALL revocations must be sent in writing to the entity releasing the PHI at the address provided above. A revocation is not effective until the later of the date it is received by the entity or any other date specified in the revocation. The Philadelphia University Student Health Services will accept written revocations of this Authorization, sent to the attention of Student Health Services via:

• Hand Delivery • Certified US Mail • Facsimile at 215-951-6867

Inspect and Copy: I understand that I have the right to inspect or copy my PHI to be used or disclosed pursuant to this Authorization, as permitted by law.

Conditioning Treatment: I understand that the Philadelphia University Student Health Services will not condition my treatment, enrollment in a health plan or eligibility for benefits on whether I provide Authorization for a requested use or disclosure.

I AUTHORIZE THE USE AND/OR DISCLOSURE OF MY PHI AS DESCRIBED ABOVE. I HAVE READ THE CONTENT OF THIS AUTHORIZATION, AND I FULLY UNDERSTAND AND ACCEPT ITS TERMS.

_____ _____

Signature of Patient Date

_____ _____

Witness Date

The Health Center reserves the right to authenticate patient signature on forms received by fax or mail prior to the release of requested information. Electronic signature is not accepted at this time.

FOR INTERNAL OFFICE USE ONLY **Disclosures made in response to Authorization (PHI), (date and recipient) are to be documented in the patients' medical record (PMR).**

Revocation Received: Statement and/or information mailed/faxed to parent/student/other: By On:

Authorization verified and added to the PMR: By On: Copy of Authorization given to patient, if applicable: By On: