Penn State Behrend, The Health and Wellness Center

4701 College Drive, Erie, PA 16563

(814) 898-6217 FAX: (814) 898-6924

# AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

## Student must read:

I understand that my medical record may contain information (including medications) related to **alcohol/drug abuse and/or dependence, mental health/rehabilitation, HIV and/or AIDS, and/or sexual assault**. This information will be disclosed unless I specify that the information **not** be disclosed by initialing below:

Alcohol/Drug Abuse and/or Dependence Mental Health/Rehabilitation HIV and/or AIDS Sexual Assault

## Student must complete:

**Name: Date of Birth:**

**Address: PSU ID#:**

**City, State, Zip: Telephone (with area code):**

## Student must complete authorization:

**I authorize the Health and Wellness Center to Disclose, Obtain, or Verbally Exchange Protected Health Information (PHI):**

**(Select all that apply)**

**DISCLOSE PHI TO: OBTAIN PHI FROM: VERBALLY EXCHANGE PHI WITH:**

**Name/Organization:**

**Address: Telephone (with area code):**

**City/State/Zip: Fax (with area code):**

**INFORMATION TO BE RELEASED: (at least one must be checked)**

**Immunizations Treatment Notes Laboratory/Pathology Reports Radiology Reports**

**Physical Therapy Notes Other:**

**(Records released will fall within this date range; beginning & ending dates are required. Use the format of mm/dd/yy)**

/ / **through / /**

**Purpose of this request (check one): Healthcare Payment of a claim Personal**

**Other:**

## Student must read these two paragraphs:

I understand that I have a right to revoke this authorization at any time; if I revoke this authorization, I must do so in writing and present my written revocation to the Health and Wellness Center. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire . If I fail to specify an expiration date or event, this authorization will expire 90 days from the date on which it was signed. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I also understand that the information disclosed according to this release may be redisclosed by the recipient and is no longer protected by HIPAA (Federal Regulations).

## Student must sign and date this form:

**Signature of patient or legal representative: Date:**

**If signed by legal representative, relationship to patient:**

**Signature of staff member assisting with form completion: Date:**

**For Office Use Only:**

**Date request received: Date released/obtained: Method:**

**Process completed by: Date:**