FAYETTEVILLE STATE UNIVERSITY

Student Health Services
1200 Murchison Road,
Fayetteville, NC 28301-4252
Tel: 910.672.1259 Fax: 910.672.1366

Authorization to Release Disclosure of Protected Health Information

Patient's Name: _____ Date of Birth: ____/_____/_____

Previous/ Maiden Name: _____Bronco ID: _____

Contact Phone: _____Current Classification (Fr, Soph, etc.) _____Last Yr. Enrolled: _____

I authorize FSU Student Health Services to: (check all that apply)

☐ Release Information to: ☐ Obtain Information from: ☐ Verbally Communicate Information with:

Name/ Organization: _____

Street Address: _____

City, State, Zip Code: _____

Telephone #: _____ Fax#: _____

Please release or send the following information from my health records: (Check all that apply)

___Entire Medical Record	___Pharmacy Record	___Physical Exam
___Women's Health	___Consultation Report	___Immunizations
___Depo Notes	___Psychiatric Treatment Summary	___Billing Record
___X-Ray and Imaging Report	___Counseling Treatment Summary	___Lab Results

___ Other (please specify) _____

Specify Date(s) of Service/Treatment: (all dates included unless otherwise indicated) _____
Limitation of this Authorization: (if nothing indicated, no limitations) _____

Purpose of Disclosure:

___Administration/Academic Coordination	___Employment	___Medical Care
___Coordination of Care/Treatment	___Insurance	___Personal
___Guardian Communication	___Other (please specify) _____	

- I understand that I may refuse to sign this Authorization. The Student Health Center will not condition my treatment, any payment, or eligibility for benefits on receiving my signature on this Authorization.
- I understand information disclosed pursuant to this authorization may include treatment/care of HIV/AIDS, drug/alcohol abuse and /mental/behavioral health.
- I understand that my information may be re-disclosed by the authorized person/organization receiving the information, and at that point, the authorized person/organization may not be required to protect the privacy of my information.
- I may revoke this Authorization at any time by providing a written notice to the SHS, and Medical Records Department.
- I understand that the revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim under my policy.
- The revocation will not apply to information previously released in response to this Authorization.
- I agree that a copy of this release or electronic or faxed submission of this release should be as valid as this original release.
- I understand a fee will be charged to cover the cost of copying.
- I understand that a valid photo ID must be submitted with the completed request.
- This authorization expires in one year (365 days) or _____ (specify date other than 1 yr.)

Disclosure Method: (check one):

☐ Pick-Up (ID Required) Person picking up records:_____
☐ Mail to Name/Organization ☐ Fax ☐ Secure Message (**Active student only**)

Signature of Patient or Legal Representative: _____ Date: _____

Signature of Witness: _____ Date: _____