University of Delaware, Student Health Services
Laurel Hall, Newark, DE 19716-8101

AUTHORIZATION FOR RELEASE
OF PROTECTED HEALTH INFORMATION TO STUDENT HEALTH SERVICES

Please Print

PATIENT NAME_____ UD ID #_____

CURRENT ADDRESS_____

TELEPHONE_____ DATE OF BIRTH_____

I hereby authorize _____

Address: _____

Phone: _____ Fax: _____

(Hereafter known as the Treating Facility) to release to:

Attention: _____

University of Delaware, Student Health Services

282 The Green, Laurel Hall, Newark, DE 19716-8101

Phone: 302-831-2226, Fax: 302-831-6407

the following information as designated below (Check appropriate line):

____ **Whole medical record** (including records forwarded from previous healthcare provider and reports from referral healthcare providers). (To exclude HIV/STI testing, check this box ☐)

____ **Women's Health record only (**including laboratory reports**)**
(To exclude HIV/STI testing, check this box ☐)

____ **Medical record from (date) _____ to (date) _____ related to my problem/condition**

_____

____ **Diagnostic test results only**:

Type(s) _____ Date(s) _____

Type(s) _____ Date(s) _____

Reason for Disclosure: Follow up and/or continued medical treatment

- I understand that this request for release of information stands effective for 120 days from the date it is signed or until _____. I may revoke this Authorization at any time. I understand that my revocation must be in writing, signed by me or on my behalf, and delivered to the Treating Facility. My revocation will be effective upon receipt, but will not be effective to the extent that the Treating Facility has taken action in reliance upon this Authorization.
- Disclosure of specific information authorized for release is limited to the above-mentioned recipient only.
- I understand that treatment, payment, enrollment or eligibility for benefits at the Treating Facility cannot be conditioned on the signing of this authorization.
- I also understand that once released, the Treating Facility has no control over any re-disclosure of my records that may occur, and my information may be subject to redisclosure by the recipient and no longer protected by law.

SIGNATURE _____DATE _____ TIME _____

PRINT NAME _____

If not signed by the patient, indicate your relationship/authority to sign for the patient _____

Records Requested by: Name _____ Date _____ Time _____

UNIVERSITY OF DELAWARE
STUDENT LIFE