Student Health Services
Division of Student Affairs
777 Glades Road, SS-8W 240
Boca Raton, FL 33431
tel: 561.297.3512
fax: 877.592.8688
www.fau.edu/shs

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name:____ Date of Birth:____________________
(Please Print)
Student ID/Z#:_______________________________________ Telephone:______________________

Address: ____

Verification of identity: ☐ Driver's License/State ID ☐ Personally known ☐ Other

I hereby authorize Florida Atlantic University Student Health Services to (choose one):
- ☐ use or disclose my protected health information as indicated below **to**:
- ☐ obtain my protected health information **from**:

Name:____ ___ Will pick-up in person
___ Please mail to address noted
Address:____ ___ Please fax to # ______________

For purposes of (describe purpose) and time period (dates):____

Records requested:
- ☐ Immunization records
- ☐ Partial record, as specified (include date of visit if applicable):______________________
____
- ☐ Other (describe record and/or information):_________________________________
____

I understand that this health information may include sensitive information. By signing this area below, I am specifically authorizing the release of information relating to:
________ (initial here) HIV/AIDS and sexually transmitted disease information
________ (initial here) Alcohol and substance abuse information
________ (initial here) Mental health information and psychotherapy notes

Signature:____ Date:__________________

I have read and understand the following statements of my rights:
- This authorization will remain in effect for one (1) year or until I revoke it in writing. However, the revocation will not have any effect on any actions taken before its receipt and processing.
- I may see and copy the information described on this form, if requested.
- I am not required to sign this form to receive my health care benefits, and my refusal to sign this authorization will not affect my treatment, payment, enrollment, or eligibility for benefits or the quality of care that I will receive.
- I received the Notice of Privacy Practices and had the opportunity to ask questions about it, as well as about the use and disclosure of my health information before signing. The Notice of Privacy Practices is subject to change at any time.
- I understand that information released pursuant to this authorization may no longer be protected by state law or the federal health privacy law and could be re-disclosed by the person or entity that receives it.
- I am aware that the charge for copying records is $1.00 per page for the first 25 pages and $0.25 for each additional page thereafter. Please allow up to five (5) business days for copies to be made. Fees are waived when health information is released to a health care provider for treatment purposes.
- A copy of this authorization is as valid as the original and is subject to its terms and conditions.

Execution by Patient or his/her authorized representative:

Signature:____ Date:__________________

Relationship to Patient:______________________________

For Office Use Only:	
Date picked up/mailed/faxed:	Staff Initial