

OSU University Health Services

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This form authorizes UHS to use or disclose the personal health information listed below for the purposes stated below.

Printed Name: _____ CWID: _____ DOB: _____ Phone: _____

Facility/Person authorized to SEND information

Facility/Person authorized to RECEIVE information

PH _____ Fax _____

PH _____ Fax _____

I understand this information may be transmitted by fax if necessary for urgent medical care.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE, NON-COMMUNICABLE, OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASE SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND HUMAN IMMUNODEFICIENCY VIRUS ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

I also understand that I may revoke (in writing) this consent at any time except to the extent that action has been taken in reliance on and I also 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. In any event this consent expires automatically as described below. Specification of the date, event or condition upon which this consent expires _____ not to exceed 12 months, if left blank this consent expires six months from date of signature.

Personal Health Information to be used or disclosed:

_____ Visit Summaries; _____ Lab, EKG, and/or X-ray CD/reports; _____ Billing Information _____

Psychiatric evaluations; _____ Medication History or management; _____ other mental health records;

_____ Other _____

_____ Entire record of care provided by this office's health care professionals exclusive of the four items below. If you wish any of these 4 items transferred, you must initial.

Table with 4 columns: Item, Include, Item, Include. Rows include AIDS or AIDS(HIV) antibody test results, Alcohol or substance abuse or treatment, Records from other provider offices, Psychiatric/mental health diagnosis or treatment.

I understand that once disclosed this information may be re-disclosed by the recipient who might not be subject to HIPAA regulations, which means the information may no longer be protected. More information regarding your privacy rights is found in the UHS Notice of Privacy Practices. I understand that UHS does not condition treatment upon my willingness to sign this authorization. If the person requesting this authorization for use of PHI is NOT the individual, please state the authority under which this request is being made: _____

Signature of Patient (or if under 18 years of age, Parent, Legal Guardian, Legal Representative) _____ Date _____

Clinic Use Only

Released By: _____ Date: _____ Mail/Fax _____ Pick up _____ Call when ready _____