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| ***last year attended*:** |

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

       

Name of Patient/Previous Names Phone Number Birth Date E-Number/SSN

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| **Charges Apply:**  **$20 (up to 40 pages)**  **($0.25 per any additional page)**  **PLUS CERTIFIED MAIL COST: $10**  **Prepayment is Required!** |

   

Street Address City State Zip

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| **AUTHORIZES: RELEASE OF PROTECTED HEALTH INFORMATION:**  By signing this Authorization Form., I understand that I am giving my authorization for ETSU to use and/or disclose my protected health information (PHI), as described in more detail below, to the following person(s) or organization(s):   |  |  | | --- | --- | | **TO:**    Name of Health Care Provider/Plan/Other Phone Number Fax Number    Street Address City State Zip | **FROM:**  East Tennessee State University Student/University Health Services  Suite 160, Roy S. Nicks Hall  Phone: (423) 439-4225  Fax: (423) 439-4560  E-mail: shserv@etsu.edu | | **INFORMATION TO BE RELEASED: ENTIRE RECORD\_\_\_\_\_\_\_\_, or:** | | | **For the reasons below which require special permission to release otherwise privileged information, please release records pertaining to:**    **Other (Specify):**  **For the Following Date(s):** | | | **PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)** | | |

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| **I understand that if the person(s) and/or organizations(s) listed above are not health care providers, health plans or health care clearinghouse, who must follow the federal privacy standards, the health information disclosed was a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.**  **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**  ***Right to Inspect or Copy the Health Information to Be Used or Disclosed***- **I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Student Health Services*. Right to Receive Copy of This Authorization*- I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. If I am providing authorization for marketing purposes, I understand that ETSU may receive remuneration from a properly authorized business associate as a result of using or disclosing my PHI. *Right to Revoke This Authorization*- I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact: Student Health Services\_. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above that already made in reference to this authorization.** | | |
|  |  |  |
| **EXPIRATION DATE:** This authorization is good until the following date(s)    -  oruntil the following event occurs: | | |
| **I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.** | | |
| **Signature Patient/Legal Rep:**  **Witness:** | | **Date:** |
|  |  |  |

**\*PLEASE ALLOW UP TO 10 DAYS FOR COMPLETION**