University of Delaware, Student Health Service

Laurel Hall
Newark, DE 19716-8101
(302) 831-2226 Fax (302) 831-6407

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please Print

PATIENT NAME_____ UD ID #_____

CURRENT ADDRESS_____

TELEPHONE_____ DATE OF BIRTH_____

I hereby authorize the University of Delaware Student Health Service to release to:

NAME _____

ADDRESS _____

TELEPHONE _____ FAX _____

Check appropriate line:

_____ **Immunization/PPD Results & associated chest X-ray only** (*Does not require administrative signature for release*)

_____ **Diagnostic test results only**:
Type(s) _____Dates_____

_____ **Gynecology record only**

_____ **Partial medical record related** to my problem with **_____ from _____ to_____**

_____ **Whole medical record** while attending the University of Delaware (**Including** treatments for sexually transmitted diseases, pregnancy, gynecology visits, HIV counseling/testing information, and drug or alcohol diagnosis/treatment/referral information.)

_____ **Illness Verification letter** from Student Health Service Director to College of **_____** related to my problem with **_____ from (date) _____to (date) _____**

Reason for Disclosure _____

- 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: University of Delaware, Student Health Service, Laurel Hall, Newark, DE 19716-8101. My revocation will be effective upon receipt, but will not be effective to the extent that the University of Delaware Student Health Service 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 University of Delaware Student Health Service cannot be conditioned on the signing of this authorization.
- I also understand that once released, University of Delaware Student Health Service 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 _____

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ID VERIFICATION _____ YES _____ NO SHS WITNESS _____

APPROVAL OF STUDENT HEALTH SERVICE DIRECTOR OR ASSISTANT DIRECTOR FOR NURSING SERVICE:

_____

Records were ☐ SENT ☐ TELEPHONED ☐ FAXED ☐ GIVEN to Authorized Entity/Individual listed above by:

Name _____ Title _____ Date _____ Time _____