THE LEADER IN GLOBAL EDUCATION

FAIRLEIGH DICKINSON UNIVERSITY

STUDENT HEALTH SERVICES
Metropolitan Campus
1000 River Road, T-SU2-03
Teaneck, NJ 07666
201-692-2437 **Voice**
201-692-2642 **Fax**

AUTHORIZATION TO DISCLOSE HEALTH RECORDS

This form when completed and signed by you, authorizes the University to release protected information from your clinical record to the person or agency you designate

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1) I hereby give permission to: ☐ Student Health Services

2) To disclose the protected health information of:

Student's Name: _____ Student ID: _____

Contact Phone #: _____

3) Name of person or organization to release, obtain, or discuss the protected health information:

☐ Release information to: _____

☐ Obtain information form: _____

☐ Discuss information on an ongoing basis with: _____

4) The records are to be:

☐ Picked up by: _____

☐ Mailed to Address/City/Zip _____

☐ Faxed to #: _____

5) Purpose of disclosure (check all that apply):

☐ Further healthcare _____ ☐ Verification of attendance

☐ Further mental health evaluation/treatment _____

☐ Legal investigation ☐ Payment of insurance claim ☐ Planning and/or coordination of ongoing care

☐ Personal use ☐ Academic accommodations

☐ Other: _____

STUDENT HEALTH SERVICES TO BE DISCLOSED *(turn page over for service options)*

Please check the appropriate sections of the health record to be released (check all that apply):

☐ Records only related to the following date(s) of service: _____

☐ Record of attendance at appointments ☐ Specific lab and/or Radiology Results

☐ Immunizations ☐ Most Recent Gynecological Exam/ Pap Smear

☐ All Medical Note(s)*** ☐ Special Medical Notes: _____

☐ Records which may indicate the presence of a communicable disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and HIV/AIDS treatment, testing, or discussion _____ (initial)

***Please note that an authorization for the release of all Medical Notes may disclose sensitive information about your mental health, drug or alcohol use, episodes of domestic violence or sexual assault, and history or treatment for Sexually Transmitted Infections.**

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6) Any Other Instructions about Information Released:

_____

_____

_____

I understand the N.J. and Federal Protected Health Information regulations applicable to physicians and other healthcare professionals provide certain protections for health records.I have the right to review my health records except in specific limited circumstances, and to request amendments where appropriate.

My health information may be subject to redisclosure and not protected by Federal or State Statutes in the occurrence of a medical emergency, reporting of communicable disease as required under NJ Public Health statutes, disclosure in response to a subpoena duces tecum or court order, or required disclosure to a government agency. Specific information to be disclosed in my health record may include information regarding drug or alcohol use, counseling referrals, and/or history of testing or treatment of acquired immune deficiency syndrome (AIDS) or related conditions.

This authorization shall remain in effect for one year from the date signed below or (alternate end date): _____. I understand that I may revoke this authorization at any time by notifying Fairleigh Dickinson University Student Health Services (SHS) in writing, except that revocation will not cancel any action taken by the University upon the original Authorization for Disclosure Protected Health Information.

➤ **Student Signature:** _____ **Date** _____

(Signature Required)

***Representative's Signature (if student is unable to sign):** _____

Print Representative's Name: _____ **Date** _____

*If authorization is signed by a representative of the student, relationship to student or description of such representative's authority to act for the student must be provided: _____

_____

FOR STAFF USE ONLY

➤ **Student Health Services Staff Signature** _____ **Date** _____

(Staff Signature Required)

Records Release Completion

☐ Records copied and faxed as requested ☐ Records copied and mailed as requested

☐ Records copied and given as requested to person(s) indicated above

☐ Other _____

Completed by: _____ Date: _____

August 18, 2017