Penn State Behrend, The Health and Wellness Center
4701 College Drive, Erie, PA 16563
(814) 898-6217 FAX: (814) 898-6924

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Student must read:

I understand that my medical record may contain information (including medications) related to **alcohol/drug abuse and/or dependence, mental health/rehabilitation, HIV and/or AIDS, and/or sexual assault**. This information will be disclosed unless I specify that the information **not** be disclosed by initialing below:

_____ Alcohol/Drug Abuse and/or Dependence _____Mental Health/Rehabilitation _____ HIV and/or AIDS _____ Sexual Assault

Student must complete:

Name: _____ **Date of Birth:** _____

Address: _____ **PSU ID#:**_____

City, State, Zip: _____**Telephone (with area code):** _____

Student must complete authorization:

I authorize the Health and Wellness Center to Disclose, Obtain, or Verbally Exchange Protected Health Information (PHI):

(Select all that apply)

_____ DISCLOSE PHI TO: _____OBTAIN PHI FROM: _____ VERBALLY EXCHANGE PHI WITH:

Name/Organization: _____

Address: _____ **Telephone (with area code):** _____

City/State/Zip: _____ **Fax (with area code):**_____

INFORMATION TO BE RELEASED: (at least one must be checked)

_____ Immunizations _____ Treatment Notes _____Laboratory/Pathology Reports _____ Radiology Reports

_____ Physical Therapy Notes Other: _____

(Records released will fall within this date range; beginning & ending dates are required. Use the format of mm/dd/yy)

_____ / _____ / _____ **through** _____ /_____ /_____

Purpose of this request (check one): _____Healthcare _____Payment of a claim _____ Personal

Other: _____

Student must read these two paragraphs:

I understand that I have a right to revoke this authorization at any time; if I revoke this authorization, I must do so in writing and present my written revocation to the Health and Wellness Center. I understand that the revocation will not apply to information that has already been released in response to this authorization. I 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.

This authorization will expire _____ . If I fail to specify an expiration date or event, this authorization will expire 90 days from the date on which it was signed. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I also understand that the information disclosed according to this release may be redisclosed by the recipient and is no longer protected by HIPAA (Federal Regulations).

Student must sign and date this form:

Signature of patient or legal representative: _____ **Date:** _____

If signed by legal representative, relationship to patient: _____

Signature of staff member assisting with form completion:_____ **Date:** _____

For Office Use Only:

Date request received:_____ **Date released/obtained:** _____ **Method:** _____

Process completed by: _____ **Date:** _____