UVU STUDENT HEALTH SERVICES
UTAH VALLEY UNIVERSITY

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Student ID: _____

Date of Birth: _____ Phone#: _____

Approximate Dates of Treatment: _____

Purpose of the requested use or disclosure:

- ☐ Continued Care and Assessment
- ☐ Personal Use
- ☐ Legal Purposes
- ☐ Other (Specify): _____

Release Protected Health Information FROM:

- ☐ UVU Student Health Services
  800 W. University Pkwy MS200
  Orem, UT 84058
  Fax: 801-863-7056
  Phone: 801-863-8876
- ☐ Other Medical Office or Entity:
  Facility: _____
  Medical Professional: _____
  Individual: _____
  Phone: _____
  Address: _____
  _____
  Fax: _____

Release Protected Health Information TO:

- ☐ UVU Student Health Services
  800 W. University Pkwy MS200
  Orem, UT 84058
  Fax: 801-863-7056
  Phone: 801-863-8876
- ☐ Other Medical Office or Entity:
  Facility: _____
  Medical Professional: _____
  Individual: _____
  Phone: _____
  Address: _____
  _____
  Fax: _____
- ☐ Yourself
  Address: _____
  _____

Please include the following information:

- ☐ Lab Report
- ☐ Immunizations
- ☐ History/Physical
- ☐ Psychosocial History
- ☐ Treatment Plans
- ☐ LD Testing Report
- ☐ Other: _____

I understand that the medical records released pursuant to this authorization could contain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious diseases which are subject to federal and/or state disclosure restrictions. By my signature below, I specifically authorize the disclosure of those records. I also understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

This permission to disclose my protected health information is valid for a period of ONE (1) year, or until _____, whichever occurs first. I understand that I can change my mind and cancel or revoke this permission at any time by sending a letter to UVU Student Health Services at the address given above. That revocation shall include all but the information that has already been disclosed or released pursuant to this authorization and prior receipt of the revocation. I hereby affirm that I have read and fully understand the statements above and consent to the disclosure of the protected health information for the purpose and extent stated.

Signature of Patient or Legally Authorized Representative: _____

Relationship to Patient: _____ Date: _____