BOWIE STATE UNIVERSITY
Prepare For Life

WELLNESS CENTER

Patient Authorization to Release Protected Health Information (PHI)(PHI)

Patient Name: _____ Phone Number: _____

Mailing Address: _____

Student ID: _____ Date of Birth: _____ Today's Date: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

I HEREBY AUTHORIZE THE DISCLOSURE AND USE OF MY HEALTH INFORMATION: [CHECK AS APPROPRIATE]

__ **From or** __ **To**
Bowie State University
Christa McAuliffe Resident Hall, LL
14000 Jericho Park Road
Bowie, MD 20715

__ **From or** __**To**
Name: _____
Street Address: _____
_____
City, State, Zip: _____
Phone: _____
Fax: _____

DATES OF RECORDS/INFORMATION
FROM: ____/____/____ TO: ___/___/___
TYPES OF RECORD(S) INFORMATION
[Check as appropriate]
__ Entire Medical Record __Immunization Record(s)
__ Lab Result(s) __Prescriptions/ Pharmacy Record(s)

Please Note: This Authorization applies ONLY to the information indicated above, and information will be sent ONLY to the above address or fax number. Additional Information or disclosure to another person or entity or another address or fax will require another Authorization.

METHOD OF DISCLOSURE
Please release my records/information via: [Check as appropriate]
__ Mail __ Fax __in person pick-up by patient __Verbal by phone (verified by two witness)

PURPOSE OF AUTHORIZATION
The authorization is for the following purpose: [Check one and complete as needed]
__Personal Use __Patient Care __Legal __Parent/Guardian Communication __Insurance __Other

EXPIRATION OF AUTHORIZATION
[Insert defined event or date not later than three months from the date Authorization is signed]
This Authorization will expire on: _____.

Patient Acknowledgement-Please Read Carefully

Re-disclosure: I understand that when the information is disclosed pursuant to this Authorization to someone who is not required to comply with the federal or state privacy protection requirements, it may be subject to re-disclosure by the recipient and may no longer be protected.
Revocation: I further understand that I retain the right to revoke this Authorization at any time, if I do so in the manner set forth below. I understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my PHI have already acted in reliance on this Authorization. In order for my revocation to be effective, it must be in writing.

Christa McAuliffe Resident Hall, LL, 14000 Jericho Park Road, Bowie, MD 20715 Phone 301-860-4170 Fax 301-860-4179

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The revocation must include:
- The patient's name, address and identification number, if applicable
- Sufficient information to identity this Authorization including date and recipient of PHI
- The patient's desire to revoke this Authorization
- The intended date of the revocation, if later than the receipt of the revocation, and
- The patient's signature

ALL revocations must be sent in writing to the entity releasing the PHI at the address provided above. A revocation is not effective until the date it is received by the entity or any other date specified in the revocation. Henry Wise Wellness Center will accept written revocations of this Authorization, sent to the attention of the Henry Wise Wellness Center
via: • Hand Delivery • Certified US Mail • Facsimile at 301-860-4179

Inspect and Copy: I understand that I have the right to inspect or copy my PHI to be used or disclosed pursuant to this Authorization, as permitted by law.

Conditioning Treatment, etc: I understand that the Henry Wise Wellness Center will not condition my treatment, enrollment in a health plan or eligibility for benefits on whether I provide Authorization for a requested use or disclosure except in limited circumstances, such as certain research related treatment or health care solely for the purpose of providing information to another person or entity.

I AUTHORIZE THE USE AND/OR DISCLOSURE OF MY PHI AS DESCRIBED ABOVE. I HAVE READ THE CONTENTS OF THIS AUTHORIZATION, AND I FULLY UNDERSTAND AND ACCEPT ITS TERMS.

_____ _____
Patient or Personal Representative Signature **Date**

_____ _____
Print Name of Personal Representative Relationship to Patient

FOR INTERNAL OFFICE USE ONLY

Authorization verified and added to the patient's medical record:
By_____ On: _____

Statement and/or information mailed/faxed to parent/student/other:
By_____ On: _____

Copy of Authorization given to patient, if applicable:
By_____ On: _____