AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTHCARE INFORMATION TO STUDENT HEALTH SERVICES

Florida Gulf Coast University
Student Health Services
(239) 590-7966 phone
(239) 590-7575 fax

Please Circle One **Fax** **Mail** **Pick-up**

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

University Identification Number (UIN) _____ **Telephone Number:**_____

INFORMATION MAY BE RELEASED BY:

Person/Facility _____ Phone#:_____

Address: _____ Fax #: _____

INFORMATION MAY BE RELEASED TO:

Florida Gulf Coast University Student Health Services
10501 FGCU Boulevard South
Fort Myers, FL 33965
(239) 590-7966 phone
(239) 590-7575 fax

INFORMATION TO BE RELEASED: (Initial Your Selections)

___ General Medical Record(s) including STD ___ Progress Notes ___ History and Physical Results

___ Consultations ___Gynecological Records ___X-ray/Radiology ___Family Planning

___ Lab Test Reports (Specify type of test(s)_____

Other: Please Specifiy _____

Release records pertaining to the following dates: From:_____ To:_____

I specifically authorize the release of information relating to: (Initial all that apply)

___ HIV Test Results ___ Substance Abuse Service Records

PURPOSE OF DISCLOSURE:

___ Continuity of Care ___ Personal Use - Other -Please specify _____

EXPIRATION DATE: This authorization **will expire 90 days** after the date of my signature. Information documented in my record after the date of my signature will not be released, without my further authorization.

REDISCLOSURE: I understand that once the information above is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

REVOCATION OF AUTHORIZATION: I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the appropriate medical records department. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revoking this authorization has no impact on any payment for services rendered.

_____ _____
Patient/Representative Signature Date

_____ _____
Printed Name Representative's Relationship to Patient

_____ _____
Witness Date