AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

☐ Enrolled
☐ Alumni
last year attended:

Charges Apply:
$20 (up to 40 pages)
($0.25 per any additional page)
PLUS CERTIFIED MAIL COST: $10

Prepayment is Required!

Name of Patient/Previous Names _____ Phone Number ( ) - _____ Birth Date / / _____ E-Number/SSN _____

Street Address _____ City _____ State _____ Zip _____

AUTHORIZES: RELEASE OF PROTECTED HEALTH INFORMATION:

By signing this Authorization Form., I understand that I am giving my authorization for ETSU to use and/or disclose my protected health information (PHI), as described in more detail below, to the following person(s) or organization(s):

TO:

Name of Health Care Provider/Plan/Other _____ Phone Number ( ) - _____ Fax Number ( ) - _____

Street Address _____ City _____ State _____ Zip _____

FROM:
East Tennessee State University
University Health Center
Box 70675 Johnson City, TN 37614
Phone: (423) 439-4225
Fax: (423) 439-4560
Email: shserv@etsu.edu

INFORMATION TO BE RELEASED: ENTIRE RECORD_____, or:

☐ Medical History, Examinations, Reports ☐ Surgical Reports ☐ Immunizations ☐ Consultations
☐ Treatment or Tests ☐ Hospital Records Including Reports ☐ X-Ray Reports
☐ Allergy Records ☐ Laboratory Reports ☐ Prescriptions

For the reasons below which require special permission to release otherwise privileged information, please release records pertaining to:

☐ Mental Health ☐ Developmental Disabilities ☐ Alcoholism ☐ HIV (AIDS) ☐ Sexually Transmitted Disease ☐ Drug Abuse

Other (Specify): _____

For the Following Date(s): _____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

☐ Further Medical Care ☐ Legal Investigation or Action ☐ Personal ☐ Insurance Elgibility/Benefits ☐ Changing Physicians

I understand that if the person(s) and/or organizations(s) listed above are not health care providers, health plans or health care clearinghouse, who must follow the federal privacy standards, the health information disclosed was a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

***Right to Inspect or Copy the Health Information to Be Used or Disclosed*- I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting University Health Center. *Right to Receive Copy of This Authorization*- I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. If I am providing authorization for marketing purposes, I understand that ETSU may receive remuneration from a properly authorized business associate as a result of using or disclosing my PHI. *Right to Revoke This Authorization*- I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact: University Health Center_. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above that already made in reference to this authorization.**

EXPIRATION DATE: This authorization is good until the following date(s) / / - ___/___/___

or until the following event occurs: _____

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature Patient/Legal Rep: _____ **Date:** ___/___/___

Witness: _____

***PLEASE ALLOW UP TO 10 DAYS FOR COMPLETION**