



Authorization for Release of Patient Health Information

PATIENT NAME First and Last	Student ID#:	DOB Month/Day/Year	AGE:
TELEPHONE#:	Emergency Contact Name:	Emergency Contact Ph#:	

SECTION A:

The undersigned hereby authorizes and requests the Dickey Health and Wellness Center to:
 Release my medical records to health Care Facility or Previous PCP or Parent(s) Rapid Trace Release my current medical status to the athletic department The University of Tampa or The University of Tampa professors or Self.

Complete SECTION C: Specific information requested.

Enter contact info below for the Health Care Facility or Previous PCP or Parent(s) indicated above.

Full Name(s): _____ Address: _____ City _____ State _____ Zip: _____
 Telephone : _____ Fax number _____

OR

SECTION B:

The undersigned hereby authorizes and requests Name of Health Care Facility or Phone : _____ Fax: _____
 to release medical, alcohol, AND/OR substance abuse information contained in patient's medical records for the purpose of continued care to: Dickey Health and Wellness Center, The University of Tampa

401 W. Kennedy Blvd., Tampa FL 33606 Phone: _____
 (813) 253-6250 Fax: (813) 258-7413

SECTION C:

Specific information requested to Release G (check all that apply):

- | | | |
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| <input type="checkbox"/> PAP/Contraception Records | <input type="checkbox"/> X-ray and imaging Reports | <input type="checkbox"/> Immunization Record |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> ER Record | <input type="checkbox"/> Most Recent History and Physical |
| <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Entire Record | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Verbal only (please specify) _____ | <input type="checkbox"/> Other _____ | |

I authorize the release of information covering the period(s) of healthcare from: Date(s) to: Date(s) _____

I understand that signing this authorization is voluntary. My treatment, enrollment in a health plan, or eligibility for benefits will not be conditioned on the authorization of this disclosure. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, so in writing and present my written revocation to the Dickey Health and Wellness Center. I understand that information contained in my medical records contain HIV/AIDS testing, results, and treatment records.

I understand that the revocation will not apply to information that has already been released in response to this authorization and that the revocation will not apply to my insurance company when the law provides my insurer with the right to claim under my policy. I understand that disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of health information, I can contact the Director of Medical Services at (813) 253-6250. The Dickey Health and Wellness Center will respond to my request within 48 to 72 hours from date of receipt.

This authorization will expire: Date _____. If not otherwise specified, this release will expire within 12 months from the date signed.

In what format would you like to receive your records? (choose one):

- Paper (please send to the address in section A) E-mail using secure mail (F X U S Q L O M P U J L P S I V X G R C O W) V
 I wish to pick up my records (during the Dickey Health and Wellness business hours)

_____ Signature of Patient or Guardian	_____ Relation to Patient	_____ Date: Month/Day/Year
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_____ Signature of Office Witness or Notary	_____ Printed Name of Witness	_____ Date: Month/Day/Year
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