NC STATE UNIVERSITY

Authorization to Release Protected Health Information (PHI)

Student Health Services
NC State University
Raleigh, NC 27695-7304
(919) 515-2563

Patient's Name ___________________________DOB __________ID Number __________Ph. Number __________

Please check one: ☐ Current Student; Dates Enrolled _____________or ☐ **Former Student**; Dates Enrolled ______________

Please check one and provide the requested information:

☐ I hereby authorize __________________________________ to disclose my health information to Student Health Services.
Please Fax To:
•**Medical Records (888) 972-4151** •Other fax number: ________________

☐ I hereby authorize Student Health Services to disclose my health information to the following organizations or persons:

Name/Organization: ____

Address: ____City: ___________________State: _____________

Zip Code: __________ Ph. Number: _______________ Fax Number: ___________________

Purpose of the requested disclosure: ☐ At the request of the individual ______ ☐ Other ____________________________
(Initial) (State specific purpose of requested disclosure)

The following information is to be disclosed: Please initial each block

☐ Entire medical record ☐ Immunization record
☐ Women's Health * List date(s) ____
☐ Lab results * List tests/date(s) ____
☐ X-ray and imaging reports * List date(s) ____
☐ Prescription(s) * List prescription(s)/date(s) ___________________________________
☐ Health Ctr. billing information * List date(s) ____
☐ Other _________________ * List service(s)/date(s) _______________________________

I understand that the information in my health record may include information relating to sexually transmitted, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and/or treatment for alcohol or drug abuse. I do NOT authorize Student Health Services to disclose any of the following information:

☐ Sexually Transmitted diseases ☐ AIDS/HIV ☐ Alcohol/Drug Abuse ☐ Behavioral/Mental Health

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing to Student Health Services or to another provider to whom this permission to release is granted. I am aware that my revocation is not effective to the extent that the persons I have already authorized to use and/or disclose my health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that Student Health Services may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I further understand that if the persons(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by federal privacy regulations.

I agree that a copy of this release or electronic or faxed submission of this release shall be as valid as this original release. If I authorize Student Health Services to fax or e-mail the information, I realize there are inherent risks with these methods. I understand a fee will be charged to cover the costs of copying. This authorization expires in one year (365 days) or ______________________
(Specify date, if less than one year)

Signature____Date ______________________
(Patient)

Signature____Date ______________________
(Legal Guardian – if patient is 17 yrs. or younger/Personal Representative – ID required)