NC STATE

Authorization to Release Protected Health Information (PHI)

NC State University
Student Health Services
2815 Cates Avenue
Raleigh, NC 27695-7304
919.515.2563

Return form by: Fax to 1.888.972.4151, or to email medicalrecords@ncsu.edu, or mail to the address or drop off at Student Health Services

Patient's Name_____ DOB_____ ID Number_____ Ph. Number_____

Please Check One: ☐ Current Student**;** Dates Enrolled_____ or ☐ Former Student; Dates Enrolled_____

Please Choose One:

☐ I herby authorize _____ to disclose my health information to Student Health Services.
Please Fax To: Medical Records 1.888.972.4151 Other Fax Number: _____

☐ I herby authorize Student Health Services to disclose my health information to the following organizations or persons:
Please Release My PHI By: ☐ HealthyPack Portal ☐ Mail ☐ Fax ☐ Email ☐ In Person Pick-Up

Name/Organization: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Ph. Number: _____ Fax Number: _____ Email: _____

Purpose of the Requested Disclosure: ☐ At the request of the individual _____ (Initial) ☐ Other _____ (State specific purpose of requested disclosure)

The Following Information Is to be Disclosed: Please Initial Each Line

_____ Entire Medical Record _____ Immunization Record
_____ Women's Health *List date(s) _____
_____ Lab Results *List date(s) _____
_____ X-Ray and Imaging Reports *List date(s) _____
_____ Prescription(s) *List date(s) _____
_____ Health Ctr. Billing Info * List date(s) _____
_____ Other_____ * List date(s) _____

I understand that the information in my health record may include information relating to sexually transmitted diseases, 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 Abuse/Drug Abuse ☐ Behavioral Health/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 person(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 a year)

Signature _____ Date _____
(Patient)

Signature _____ Date _____
(Legal Guardian – If patient is 17 years or younger/Personal Representative – ID Required)