BOISE STATE UNIVERSITY
HEALTH SERVICES

Authorization to Obtain or Disclose Protected Health Information

Full Name: _____ Date of Birth: _____

Previous Name: _____ Phone Number: _____

University ID: _____ Email Address: _____

Requested Records

MEDICAL **For Dates From:** **To:**

- ☐ ALL Medical Records
- ☐ ONLY Health Information Specified Below
  - ☐ Chart Notes Pertaining To: _____
  - ☐ Immunization Records and TB Test
  - ☐ Lab/Pathology/Diagnostic Results
  - ☐ Sexual Health (Gyn, STI Tests and Treatment)
  - ☐ Medical Mental Health Evaluation, Psychiatry and Treatment
  - ☐ Billing Receipts and Statements
  - ☐ Other: _____

COUNSELING **For Dates From:** **To:**

- ☐ Progress Notes
- ☐ Summary Letter
- ☐ Testing Summary
- ☐ AODA Information
- ☐ Other: _____
- ☐ Communication with providers about **MEDICAL** information marked on the left
- ☐ Communication with providers about **COUNSELING** information marked above

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☐ Disclose Health Information TO or ☐ Request Health Information FROM

Name/Title/Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

This authorization is valid until date specified or 1 year unless revoked in writing ☐ Other date of Expiration (if desired): _____

This information for which I am authorizing disclosure will be used for the following purpose:

☐ My Personal Records ☐ Continuation of Care ☐ Other (please describe): _____

My Rights

I understand that when I revoke this authorization, it is not effective to the extent that UHS has already relied on the use or disclosure of the protected health information. I understand the protected health information released pursuant to this authorization might be re-disclosed by the party who receives that information and may no longer be protected by federal or state law. UHS will not base my treatment or payment on whether I provide an authorization for the requested use or disclosure, unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party. I understand that I have a right to refuse to sign this authorization. To revoke this authorization, please submit our Revocation of Authorization form to the UHS privacy officer. If you have any questions concerning this form call (208) 426-1459.

Specific Authorization: I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have indicated otherwise.

Disclaimer and Signature

*HIPAA gives you the right to request a copy of all your medical records. Health Services acknowledges and supports your right to have access to your medical records. Health Services will provide a complete copy of your medical records to you at **no charge for the first request**. For every request thereafter you will be charged $25.00 for the first 20 pages and $0.15 for each additional page in excess of 20 pages. Payment for records will be required **before** you will receive your requested records.*

Signature: _____ Date: _____

For Office Use Only

_____ _____ Records were: ☐ Mailed ☐ Faxed ☐ Patient Pick-Up ☐ Other: _____

Date Completed By (print name)

1910 University Drive Boise, Idaho 83725-1351
Phone (208) 426-1459 Fax (208) 426-3005