University Health Services

AUTHORIZATION FOR RELEASE OF STUDENT MEDICAL OR ATHLETIC MEDICINE INFORMATION

University Health Services
McCosh Health Center, Princeton, NJ 08544
Medical Services- Ph: 609-258-3141, Fax: 609-258-1355
Athletic Medicine- Ph: 609-258-3141, Fax: 609-258-1355

Status - Check One
- ☐ **PU Undergraduate Class** _____
- ☐ **PU Grad Student - Last Year Attended:** _____
- ☐ **Dependent** _____
- ☐ **Seminary - Last Year Attended:** _____

I hereby authorize Princeton University Health Services to use or disclose my health information as described below. I understand that this authorization is voluntary and I may refuse to sign it. **I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by privacy policies or regulations.** (See exceptions below)

Patient name: _____ **Date of Birth:** _____ **Email:** _____ **Phone:** _____

I hereby authorize disclosure of my health information as follows: (Check all that apply)
For some items there is a charge.

- ☐ **Complete Medical/health information** for all services: History and Physical Exam; Progress Notes; Laboratory Tests, Physician Orders, X-ray Reports, Inpatient Admissions, Physical Therapy.
- ☐ **HIV Test Results**
- ☐ **Health information related to the following date(s) of service** _____**only**
- ☐ **Immunization health information only**
- ☐ **X-ray film copy and reports only** ☐ **CD of X-ray exam and reports**
- ☐ **Most Recent Gynecological exam/health information only**

(Disclosure of HIV-related information is controlled by New Jersey law, N.J.S.A. 26:5C. Disclosure of certain alcohol and drug abuse information is controlled by federal law, 42 C.F.R. Part 2. RECIPIENTS: please note that re-disclosure of either type of information is prohibited without additional written authorization unless otherwise permitted by state or federal law.)

The purpose of this release of information is for:

- ☐ **Transfer of Records/Disclosure of clinical information to another provider for reasons of**:
  - ☐ Evaluation; ☐ Treatment planning; ☐ Continuity of care;
  - ☐ Other: _____
- ☐ **Obtain clinical information from another provider**
- ☐ **Insurance Claims Information**
- ☐ **Personal Use**
- ☐ **Other (Describe)** _____

I hereby authorize my records from _____ to be released to:

Select: [UHS] or [Other Entity] Please Enter Other Entity's Fax # _____

_____
[Name]

_____
[Address]

_____
[Phone & Fax]

Expiration (check one)
- ☐ 90 days from the date on which I, or my legal representative, signs this authorization; or
- ☐ Less than 90 days (please specify): _____

Right to Revoke: I understand that I may revoke this authorization at any time by providing written notice to University Health Services. I understand that my revocation will not affect actions taken before receipt of the revocation by University Health Services.

I understand that the University will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on my signing this authorization.

_____ _____
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE Date

_____
PRINTED NAME OF PATIENT

If patient's legal representative: Printed Name: _____ and Relationship to patient: _____

_____ _____
WITNESS Date