



**AUTHORIZATION FOR RELEASE OF STUDENT MEDICAL OR ATHLETIC MEDICINE INFORMATION**

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

Status - Check One	
<input type="checkbox"/>	PU Undergraduate Class _____
<input type="checkbox"/>	PU Grad Student - Last Year Attended: _____
<input type="checkbox"/>	Dependent _____
<input type="checkbox"/>	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 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