



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	
<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 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