University Health Services

AUTHORIZATION FOR RELEASE OF INFORMATION
Occupational Health Services
University Health Services
McCosh Health Center, Princeton, NJ 08544
Ph: 609-258-5035, Fax: 609-258-0976

STATUS – please check one
_____Faculty/Staff
_____PU Undergraduate/Graduate Student
_____Contracted Employee
_____Dependent

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)*

Client Name_____Date of Birth_____Email_____Ph _____

I hereby authorize disclosure of my health information as follows: (Check all that apply)

☐ **Complete medical/health information** for all services: History and Physical Exam, Progress Notes, Laboratory Test, Physician Orders, X-ray Reports, Inpatient Admissions, Physical Therapy.

☐ **HIV Test Results only**

☐ **Health information related to the following date(s) of service_____only**

☐ **Immunization health information only**

☐ **CD of X-ray exam and reports**

(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:

☐ **Evaluation**
☐ **Treatment planning**
☐ **Continuity of care**
☐ **Insurance claims information**
☐ **Personal use**
☐ **Other:**

I hereby authorize_____to: ☐ release to ☐ obtain from ☐ exchange with
[UHS or other Entity]

Name _____

Address _____

Phone & fax _____

Expiration (check one)

☐ 12 months from the date on which I, or my legal representative, signs this authorization; or
☐ Other (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 Client or Legal Representative _____ Date _____

Printed Name of Client or Legal Representative_____ Relationship to Client _____

Witness_____ Date _____

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STATUS – please check one
_____Faculty/Staff
_____PU Undergraduate Class _____
_____PU Grad Student- Last Year Attended _____
_____Dependent

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

Client Name_____Date of Birth_____Email_____Ph _____

I hereby revoke my authorization to release my records from_____to_____.

Effective Date _____

Signature of Client or Legal Representative_____ Date_____

Printed Name of Client or Legal Representative_____ Relationship to Client _____

Witness_____ Date_____