Authorization To Use And/Or Disclose Health Information (Release from SEU)

Saint Elizabeth University
MORRISTOWN, NJ

FOR OFFICE USE ONLY

❑ PATIENT GIVES AUTHORIZATION
❑ PATIENT REFUSES TO GIVE AUTHORIZATION

I, (name of patient) ________________________________ (DOB) _____ / ____ / ____ ,

Undergraduate ❑ Gradute & Continuing Studies ❑ Date of attendance________________

Authorize Saint Elizabeth University Health Services to use and/or disclose my health information as identified below to:

❑ ____________ Mother / Guardian	❑ ____________ Coach	❑ ____________ Physician	❑ ____________
❑ ____________ Father / Guardian	❑ ____________ SEU Athletics Department	❑ ____________ Faculty	❑ ____________
❑ ____________ Dean's Office	❑ ____________ Resident Director/Asst.	❑ ____________	❑ ____________

Records pertaining to:

❑ medical record	❑ physical exam	❑ immunization records	❑ lab results	❑ mental health
❑ HIV	❑ STD	❑ substance abuse	❑ sexual assault	❑ confirmation of visit

I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist to be sent to:

Name/Organization ________________________________

❑ Address________________________________

____

❑ Fax ________________________________

❑ Phone Number ________________________________

❑ Email (non confidential)________________________________

Unless revoked earlier, this authorization will expire:

_____________ 365 days from date of signing

_____________ upon the following date (give specific date)__________________

_____________ upon the following event (e.g., end of semester; graduation) __________________

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I may revoke this authorization at any time by giving written notice to Saint Elizabeth University Health Services except to the extent that action has already been taken based on this authorization. I may inspect or copy any information to be used or disclosed under this authorization. I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

________________________________ ________________

Signature of Individual or Individual's Legal Representative — Date

________________________________ ________________

Print Name of Legal Representative (if applicable) — Relationship of Legal Representative

Release from SEU 6/20