

University of Delaware, Student Health Service
Laurel Hall, Newark, DE 19716-8101

AUTHORIZATION FOR RELEASE
OF PROTECTED HEALTH INFORMATION TO STUDENT HEALTH SERVICE

Please Print

PATIENT NAME _____ UD ID or SS# _____

CURRENT ADDRESS _____

TELEPHONE _____ DATE OF BIRTH _____

I hereby authorize _____

Address: _____

Phone: _____ Fax: _____

(Hereafter known as the Treating Facility) to release to:

Women's Health

University of Delaware, Student Health Service

282 The Green, S. College Ave., Laurel Hall, Newark, DE 19716-8101

Phone: 302-831-8035, Fax: 302-831-8699

the following information as designated below (Check appropriate line):

_____ My **gynecology record only** (including laboratory reports)

_____ **Diagnostic tests only:**

Type(s) _____ Date(s) _____

Type(s) _____ Date(s) _____

Reason for Disclosure: Follow up and/or continued medical treatment

- I understand that this request for release of information stands effective for 120 days or until _____. I may revoke this Authorization at any time. I understand that my revocation must be in writing, signed by me or on my behalf, and delivered to the Treating Facility. My revocation will be effective upon receipt, but will not be effective to the extent that the Treating Facility has taken action in reliance upon this Authorization.
- Disclosure of specific information authorized for release is limited to the above-mentioned recipient only.
- I understand that treatment, payment, enrollment or eligibility for benefits at the Treating Facility cannot be conditioned on the signing of this authorization.
- I also understand that once released, the Treating Facility has no control over any re-disclosure of my records that may occur, and my information may be subject to redisclosure by the recipient and no longer protected.

SIGNATURE _____ DATE _____ TIME _____

PRINT NAME _____

If not signed by the patient, indicate your relationship/authority to sign for the patient _____

Records Requested by: Name _____ Date _____ Time _____