Student Health Services
Laurel Hall
282 The Green
Newark, DE 19716-8101
Phone: 302-831-2226
Fax: 302-831-6407

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ UDID: _____

Current Address: _____

Telephone: _____ Date of Birth: _____

I hereby authorize the University of Delaware Student Health Services to release to:

Name: _____

Address: _____

Telephone: _____ Fax: _____

Check appropriate line:

☐ **Immunization/PPD results and associated chest X-ray** only *(Does not require administrative signature for release)*

☐ **Diagnostic test results only:**
Type(s): _____ Dates: _____

☐ **Women's Health record** only *(To exclude HIV/STI testing results, check this box ☐)*

☐ **Partial medical record** related to my problem with _____ **from** _____ **to** _____.

☐ **Whole medical record** while attending the University of Delaware. *(**Including** treatments for sexually transmitted diseases, pregnancy, gynecology visits, HIV counseling/testing information, and drug or alcohol diagnosis/treatment/referral information.)*
To exclude HIV/STI testing results, check this box ☐

☐ **Illness verification letter** from Student Health Services Director to College of _____
related to my problem with _____ **from (date)** _____ **to (date)** _____.

Reason for Disclosure: _____

- I understand that this request for release of information stands effective for 120 days from the date it is signed or until problem resolved. 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: University of Delaware, Student Health Services, Laurel Hall, Newark, DE 19716-8101. My revocation will be effective upon receipt but will not be effective to the extent that the University of Delaware Student Health Services 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 University of Delaware Student Health Services cannot be conditioned on the signing of this authorization.
- I also understand that once released, University of Delaware Student Health Services 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 by law.

Signature: _____ **Date:** _____ **Time:** _____

Print Name: _____

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

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ID VERIFICATION ☐ YES ☐ NO SHS WITNESS _____

Approval of Student Health Services Leadership/Administration:

_____

Records were: ☐ Faxed ☐ Sent electronically via PDF ☐ Mailed ☐ Given to Authorized Entity/Individual listed above by:

Name: _____ Title: _____ Date: _____ Time: _____