



OHIO
UNIVERSITY

Ohio University Student Health Service

2 Health Center Drive

Athens, OH 45701

TEL: (740) 593-1660 FAX: (740) 593-0179

Authorization for Disclosure of Health Information

Patient Name: _____
Last First Middle Maiden/Other

Date of Birth: _____ SS# _____ Telephone: _____

Address: _____

City: _____ State: _____ Zip: _____

Records to be released from:

Ohio University Student Health Service
2 Health Center Drive
Athens, OH 45701
(740) 593-1660 or Fax (740) 593-0179

1. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

- _____ Complete health records _____ Lab results/X-ray reports _____ GYN records
- _____ Physical exam _____ Consultation reports _____ Psychiatric records
- _____ Immunization record _____ Progress Note _____ Orthopedic records
- _____ Other (please specify): _____

2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

Records to be released to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

For the purpose of: _____

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

6. If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact:

Signature of patient or legal representative

Signature of witness

Date: _____

Date: _____

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal law 42 CFR, part II.