



UNIVERSITY OF RICHMOND
STUDENT HEALTH CENTER

AUTHORIZATION FOR RELEASE OF INFORMATION
PER INCIDENT (THIS IS NOT A BLANKET RELEASE)

Instructions: The patient is required to complete this form in its entirety in order to be processed.

I authorize the following protected health information to be released from the medical record of:

Form fields for patient information: LAST NAME (PLEASE PRINT), FIRST NAMES (PLEASE PRINT), DATE OF BIRTH, EMAIL ADDRESS, UR ID, TODAY'S DATE, PHONE NUMBER, DATE OF GRADUATION, IF APPLICABLE

PURPOSE FOR DISCLOSURE (Per HIPAA Requirements)

Medical Personal Academic Insurance/Billing Legal Other (must specify):

RELEASE RECORDS FROM TO

University of Richmond-Student Health Center, Special Programs Bldg, 28 Westhampton Way, University of Richmond, VA 23173
Phone: 804-289-8064 Fax: 804-287-6466

RELEASE RECORDS FROM TO

Form fields for recipient information: NAME/ORGANIZATION, ADDRESS, CITY, STATE, ZIP CODE, PHONE, FAX

In the following format: Fax Records Pick up at Health Center Verbal Mail

RECORDS TO BE RELEASED (Per HIPAA Requirements)

Effective Period (enter date or date range):

Immunization Records Lab Reports Clinic Notes Diagnostic Reports Other

I understand that refusal to sign this authorization will not in any way affect my treatment. I understand that the information to be released may contain information from other providers, confidential HIV/AIDS related information, confidential communicable disease information, information related to drug/alcohol abuse/treatment and/or psychiatric mental health information. I understand that confidential information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal or state law.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN, IF UNDER THE AGE OF 18 DATE

RELATIONSHIP TO PATIENT

NOTICE TO RECIPIENT OF RECORDS: The attached medical information is protected by federal privacy laws. You may not make further disclosures of the information without consent of the patient. In addition, you may use the information only for the purpose(s) for which the disclosure was made.

OFFICE USE ONLY:

Office use only fields: Processed By, Date, Number of Pages Copied, Information Released, Mailed, Faxed, Picked Up, Patient Identification Verified, ROI Logged