

BOSTON UNIVERSITY STUDENT HEALTH SERVICES

General Authorization to Disclose Protected Health Information

Patient Name John Smith Date of Birth: mm/dd/yyyy Dates at BU month/year-month/year

BU ID# U123456789 Phone # your cell number Have you ever been a CELOP student? Yes No

I John Smith (name of individual or personal representative) authorize the use or disclosure of the above named individual's Protected Health Information to:

Name of organization or person: Enter name of community provider here, credential (MD, PhD, LICSW, etc.) Address: Enter address and phone number of community provider

The purpose(s) for which disclosure is authorized:

- for patient's personal records
sharing with other health care providers For coordination of care
other (please describe):

I authorize use or disclosure of the following information (check where applicable):

- entire record medication list
immunization records list of allergies
most recent encounter note most recent history/physical
lab results (list types and dates):
x-ray and imaging reports (list types and dates):
consultation reports from (please supply doctors' names):
other (please describe):

I understand that:

- 1. I may inspect or receive a copy of the Protected Health Information described by this Authorization upon payment of a reasonable fee of \$10.00 for the entire file, \$500 for my history/immunization record, or \$2.00 per individual page.
2. This Authorization is voluntary and that I have the right to refuse to sign it.
3. I may revoke this Authorization at any time by providing a written notice of revocation as specified by the Notice of Privacy Practice; however such revocation would not affect any action taken by Student Health Services in reliance on this Authorization before receipt of my written revocation.
4. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on whether I provide Authorization for any requested use or disclosure by Student Health Services unless (a) the treatment is research related, (b) the information is needed for health plan eligibility or underwriting determinations, or (c) the sole purpose of creating the information is to disclose it to a third party.
5. This Authorization will expire on: or within 6 months whichever occurs first.
6. The information used or disclosed pursuant to this Authorization, except information protected by federal regulations about confidentiality or drug and alcohol abuse records, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws.

I understand that my health record may include and I authorize disclosure of (check all that are applicable):

- Information relating to Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), including but not limited to test results and the fact that the test was taken.
Genetic testing information including test results.
Information about Sexually transmitted diseases.
Mental Health counseling and Behavioral Health notes.
Information protected by 42 CFR Part II, federal laws protecting alcohol and drug abuse records.

Student's signature here
Signature of individual/personal representative (e.g., legal guardian)

Enter date (mm/dd/yyyy)
Date

If personal representative, relation to patient

Witness signature here
Signature of Witness

Original Copy : Provider record
Copy to patient
Copy to accompany use or Disclosure