

**BOSTON UNIVERSITY
STUDENT HEALTH SERVICES**

General Authorization to Disclose Protected Health Information

Patient Name _____ Date of Birth ____/____/____ Dates at BU _____

U # _____ Phone # _____ Have you ever been a **CELOP** Student? Yes No

I _____ (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: _____

Address: _____

Address: _____

The purpose(s) for which disclosure is authorized:

for patient's personal records _____

sharing with other health care providers _____

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, \$5.00 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 of 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.

Signature of individual/personal representative (e.g., legal guardian)

Date

If personal representative, relation to patient

Signature of Witness

Date

Original copy: Provider record

Copy to patient

Copy to accompany use or disclosure