Boston University Student Health Services

Authorization to Use or Disclose Health Information – Medical Review

Patient	*Name (Last, First Middle)*		*Date of Birth*
	BU ID#		*Mobile*
	Email		*Mobile Carrier*
Communication between:	*BU Student Health Services*		
And	*Medical Review Committee*		
	Provider:	*Phone*	*Email*
	Provider:	*Phone*	*Email*
Purpose(s):	☐ Sharing with other Health Care provider ☐ Medical Review process	☐ Sharing with University Official	
Health Information Requested	☐ Summary of Treatment ☐ Immunization records ☐ Most recent encounter ☐ Lab results	☐ Medication list ☐ List of allergies ☐ Other (Please Describe Below):	
Release of Sensitive Information	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.		

I understand that:

1. This Authorization is voluntary, and I have the right to refuse to sign it.
2. 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 will not affect any action taken in reliance on this Authorization before receipt of my written revocation.
3. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on whether I provide this Authorization for any requested use or disclosure of health information 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.
4. This Authorization will expire on:_____or within 6 months whichever occurs first.
5. 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 have carefully read, and I understand this Authorization, and I have had any questions explained to my satisfaction. I expressly and voluntarily authorize the release of the health records and information as indicated above.

_____

Student Signature *Date*

Boston University Student Health, 881 Commonwealth Ave West, Boston MA 02215

Fax 617-353-3557 or 617-353-1128 Secure email SHSecure@bu.edu