UNIVERSITY OF FLORIDA
STUDENT HEALTH CARE CENTER

PO BOX 117500
Gainesville, FL 32611-7500
(352) 392-1161
Fax: (352) 392-5129

AUTHORIZATION to Use or Disclose Protected Health Information

Patient Name	Date of Birth	Telephone Number
Verification of Identity (UF ID #, SSN)		Date of Request

** Complete the following only if the person authorizing the use or disclosure is not the patient:

Name	Relationship to Patient	Legal Authority
Verification of Identity	Verification of Authority	

By signing this form, I authorize: The University of Florida Student Health Care Center

To disclose to: DEAN OF STUDENTS (352) 392-1261 ext. 105
PO BOX 114075
GAINESVILLE, FL 32611

The following protected health information: _____ Medical Records from ______ to ________
Date Date

____ Immunization Records ____ Other: (please specify)_____________________________

I further authorize the disclosure of information related to: (Check all that are approved.)

~ **Mental Health (psychiatry or psychology)** ~ **Substance Abuse** ~ **HIV/AIDS/STD**

which may be included in the protected health information listed above.

The purpose of the use or disclosure is: Medical Withdrawal

The records are to be: ______Mailed to DOS ______ Picked-up______ Faxed _352-392-5566______

I understand that, by federal law, the University of Florida may not use or disclose my health information, except as provided in the University's Notice of Privacy Practices, without my authorization. My signature on this Authorization indicates that I am giving permission for the uses and disclosures of the protected health information described above. I hereby release the University of Florida and its employees from any and all liability that may arise from the release of information as I have directed.

I understand that I have the right to revoke this Authorization at any time. If I want to revoke this authorization, I must do so in writing, and address it to the person or institution named above that I am authorizing to disclose my information. I understand that if I revoke this authorization, it will not apply to any information already released as a result of this authorization.

I understand that I may refuse to sign this Authorization. I also understand that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this Authorization.

I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.

I understand that I may be charged a fee of up to $1.00 per page (plus applicable tax and handling) for every page copied. This fee is waived for copies provided to a health care provider for continuing medical care. I understand that this fee is within the limits allowable by Florida law.

This authorization automatically expires 1 year from ______________________________________
Date or Event

Copy Charges: 1-10 pgs –no charge, 11-35-pgs -$1/pg, over 35 pgs -$0.25/pg
Fax Charges: 1-2 pgs –no charge (Will not fax over 2 pgs)

I have read and understand the information in this authorization form.

Signature of Patient or Legal Representative: ____

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