

**AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Student ID: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone#: \_\_\_\_\_

Approximate Dates of Treatment: \_\_\_\_\_

**Purpose of the requested use or disclosure:**

- Continued Care and Assessment
- Personal Use
- Legal Purposes
- Other (Specify) \_\_\_\_\_

**Release Protected Health Information FROM:**

- UVU Student Health Services  
800 W. University Pkwy MS200  
Orem, UT 84058  
Fax: 801-863-7056  
Phone: 801-863-8876
- Other Medical Office or Entity:  
Facility: \_\_\_\_\_  
Medical Professional: \_\_\_\_\_  
Individual: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Fax: \_\_\_\_\_

**Release Protected Health Information TO:**

- UVU Student Health Services  
800 W. University Pkwy MS200  
Orem, UT 84058  
Fax: 801-863-7056  
Phone: 801-863-8876
- Other Medical Office or Entity:  
Facility: \_\_\_\_\_  
Medical Professional: \_\_\_\_\_  
Individual: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Fax: \_\_\_\_\_
- Yourself  
Address: \_\_\_\_\_

**Please include the following information:**

- Lab Report
- Psychosocial History
- Other: \_\_\_\_\_
- Immunizations
- Treatment Plans
- History/Physical
- LD Testing Report

I understand that the medical records released pursuant to this authorization could contain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious diseases which are subject to federal and/or state disclosure restrictions. By my signature below, I specifically authorize the disclosure of those records. I also understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

This permission to disclose my protected health information is valid for a period on ONE (1) year, or until \_\_\_\_\_, 20\_\_\_\_, whichever occurs first. I understand that I can change my mind and cancel or revoke this permission at any time by sending a letter to UVU Student Health Services at the address given above. That revocation shall include all but the information which has already been disclosed or released pursuant to this authorization and prior receipt of the revocation. I hereby affirm I have read and fully understand the statements above and consent to the disclosure of the protected health information for the purpose and extent stated.

Signature of Patient or Legally Authorized Representative: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_