



North Carolina Central University
 Student Health Center
 Health Information Management
 1801 Fayetteville Street
 P.O. Box 19491
 Durham, NC 27707-3129
 Phone: (919) 530-6317 Fax: (919) 530-7969

OFFICE USE ONLY	
UHS ID # _____	FAX _____
ID CHECKED _____	MAIL _____
COMPLETED _____	PICK UP _____
EMPLOYEE _____	PAID _____

HIPAA Authorization for Use or Disclosure of Protected Health Information

A) I request my medical records to be released from:

B) I authorize the release of my medical information to:

 _____ (Tel) _____ (Fax)

OR

 _____ (Tel) _____ (Fax)

Specific Medical Records Requested – PLEASE INDICATE DATES OF SERVICE ____/____/____ to ____/____/____.
 (Note: Only the most recent edition/form will be sent unless dates of service are specified):

Please check the boxes adjacent to the items for which you are requesting disclosure.

- | | | |
|--|--|--|
| <input type="checkbox"/> Progress / Physician Notes | <input type="checkbox"/> Depo / Progress / Rx Notes | <input type="checkbox"/> Diagnostic/X-Ray (Specify Date) _____ |
| <input type="checkbox"/> General Health Records ¹ | <input type="checkbox"/> Psychiatry Clinic ² | <input type="checkbox"/> Emergency Dept Report (Date) _____ |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Physicals (General, Athletic, etc.) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Laboratory / Pathology Reports | <input type="checkbox"/> EKG / EMG / EEG | |

- I understand that the information in my general health records may include information relating to: Drug/Alcohol Abuse, STI/STDs, GYN Exam, PAP Smear, HIV/AIDS, Behavioral or Mental Health and Genetics.
- I understand that a summary of the Psychiatry Clinic records may be provided in lieu of complete Psychiatry records at the discretion of the Psychiatry Clinic clinician.

Please check the boxes adjacent to the reasons for disclosure.

- | | |
|---|---|
| <input type="checkbox"/> Continued Medical Care | <input type="checkbox"/> Personal Reasons |
| <input type="checkbox"/> Changing PCP & Discontinuing Care at this Office | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Leaving Town & Transferring Records to New Physician | <input type="checkbox"/> Attorney |
| <input type="checkbox"/> Other: _____ | |

- I understand that once information is disclosed, the information is subject to re-disclosure and may no longer be protected by federal privacy regulations.
- I understand that I have a right to revoke this authorization at any time except in the case that action has already been taken in regards to the request for authorization. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand the revocation will not apply to my health plan when the law provides my plan with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one (180) days from the date signed below.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment. I understand I may inspect or copy the information used or disclosed as provided in CFR 164.524. If I have questions about disclosure of my health information I can contact the Health Information Management Department Supervisor or Privacy Officer; I may also refer to the Notice of Privacy Practices provided to me at my initial visit at University Health Center or review it on University Health Center website at <https://www.nccu.edu/dsa/health-wellness/student-health-center>.

Expiration Date: _____
 (If left blank, authorization will expire in (180) days from the date signed below)

Name _____	Birthdate ____/____/____	Phone (____) _____ - _____
Address _____		
Signature of Patient or Legal Representative _____		
Relationship _____	Banner ID or Last 4-SS# _____	Date: ____/____/____

Please Note: Confidential information in North Carolina, especially regarding health or mental health records, is strictly protected. Further disclosure requires the individual's specific, written, and informed consent or authorization under North Carolina General Statute § 130A-143 or § 122C-51, unless disclosure is specifically permitted by law (e.g., treatment, payment, or court order) and federal law 42 CFR, part II.

Prohibition on re-disclosure of information pertaining to alcohol and drug abuse records: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. If you have received this document in error, please notify us immediately by telephone at (919) 530-6317.