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:

_____
_____
_____
_____ (Tel) _____(Fax)

OR

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

_____
_____
_____
_____ (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.

- ☐ Progress / Physician Notes
- ☐ General Health Records[1]
- ☐ Immunization Records
- ☐ Laboratory / Pathology Reports
- ☐ Depo / Progress / Rx Notes
- ☐ Psychiatry Clinic[2]
- ☐ Physicals (General, Athletic, etc.)
- ☐ EKG / EMG / EEG
- ☐ Diagnostic/X-Ray (Specify Date)_____
- ☐ Emergency Dept Report (Date) _____
- ☐ Other_____
  _____

1. ***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.***
2. ***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.

- ☐ Continued Medical Care
- ☐ Changing PCP & Discontinuing Care at this Office
- ☐ Leaving Town & Transferring Records to New Physician
- ☐ Other: _____
- ☐ Personal Reasons
- ☐ Insurance
- ☐ Attorney

- **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, plesae notify us immediately by telephone at (919) 530-6317.