



AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTHCARE INFORMATION FROM STUDENT HEALTH SERVICES

Florida Gulf Coast University Student Health Services (239) 590-7966 phone (239) 590-7575 fax

Please Circle One Fax Mail Pick-up

Patient Name: Date of Birth:

University Identification Number (UIN) Telephone Number:

INFORMATION MAY BE RELEASED BY:

Florida Gulf Coast University Student Health Services 10501 FGCU Boulevard South Fort Myers, FL 33965 (239) 590-7966 phone (239) 590-7575 fax

INFORMATION MAY BE RELEASED TO:

Person/Facility: Phone#:

Address: Fax #:

INFORMATION TO BE RELEASED: (Initial Your Selections)

General Medical Record(s) including STD Progress Notes History and Physical Results Consultations Gynecological Records X-ray/Radiology Family Planning Lab Test Reports (Specify type of test(s))

Other: Please Specify

Release records pertaining to the following dates: From: To:

I specifically authorize the release of information relating to: (Initial all that apply)

HIV Test Results Substance Abuse Service Records

PURPOSE OF DISCLOSURE:

Continuity of Care Personal Use - Other -Please specify

EXPIRATION DATE: This authorization will expire 90 days after the date of my signature. Information documented in my record after the date of my signature will not be released, without my further authorization.

REDISCLASURE: I understand that once the information above is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

REVOCAION OF AUTHORIZATION: I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the appropriate medical records department. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revoking this authorization has no impact on any payment for services rendered.

Patient/Representative Signature

Date

Printed Name

Representative's Relationship to Patient

Witness

Date