Old Dominion University
Yon Student Health Services
1007 Webb Center, South Wing
Norfolk, Virginia 23529
Phone (757) 683-3132; Fax (757) 683-5930

RECORDS RELEASE AUTHORIZATION

Patient Name: _____

UIN: _____

DOB: _____

Phone: _____

Patient authorizes and requests;

Person or Facility Name - _____
(Name)

Address/Phone or Fax Number - _____

_____

To provide information to;

Person or Facility Name - _____
(Name)

Address/Phone or Fax Number - _____

_____

For the purpose of _____

For the time period _____

INFORMATION TO BE RELEASED:

_____ HISTORY AND PHYSICAL EXAM
_____ LAB DATA/TEST RESULTS
_____ HIV TEST RESULTS
_____ PROGRESS NOTES
_____ X-RAY/EKG
OTHER _____

I understand that my health information may include information related to sexually transmitted diseases, mental health services or treatment for drug and alcohol abuse.
This consent will automatically revoke 180 days from the date it was signed or on _____.

SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

PROHIBITION OF REDISCLOSURE: This information has been disclosed 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 written consent of the person to whom it pertains or as 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.

J: SHC/HIM/Forms: 6/14

Office use only
Request completed by _____ Date completed _____ ROI Log _____