AUTHORIZATION TO RELEASE
PROTECTED HEALTH INFORMATION

Radford University Student Health Center
PO Box 6899
Radford, VA 24142

I, the undersigned do hereby authorize and request Radford University Student Health to release the protected health information of :_____
Patient's Full Legal Name (please print)

Patient's Information:
Address:_____ Date of Birth: _____
_____ Social Security #: _____
_____ Phone #: _____

To the Following:
Physician or Facility's Name: _____
Address: _____
_____
Telephone #: _____
Fax #: _____

Protected Health Information to be Released:

- ❑ Copy of Entire
- ❑ Notes of exam/procedures performed including yearly gyn exam
- ❑ Health History/Immunization Form
- ❑ Laboratory/EKG Reports
- ❑ Other_____

The Purpose of this disclosure is for: ____Medical Care, ____Insurance Processing, ____Legal, _____Other (Specify)

I understand that:

- My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this authorization.
- I may withdraw (revoke), in writing, this authorization by completing a "Request to Revoke Protected Health Information." Withdrawal of this authorization does not affect any protected health information disclosed prior to the receipt of written notice of revocation.
- The potential for information disclosed may be re-disclosed by the recipient and no longer protected.
- This authorization will automatically expire one year after the day below **OR** on_____
(Specify date)

SIGNATURE: _____ DATE:_____
(Signature of Patient/Parent/Legal Guardian/Representative)

_____
(Relationship to Patient)

_____ DATE:_____
(Signature of Witness)

NOTE: 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 as otherwise permitted by 42 CFR Part2.