Student Health and Counseling Center

Authorization for Release of Protected Health Information

I ____ hereby authorize the staff of the

UAF Center for Health and Counseling to release my Protected Health Information to:

Person/Agency ____

Address ____

City/State/Zip ____

Phone # ___________________________ Fax # ______________________

Check the records you wish to have released and the time period covered – and **initial each line indicating your consent**.

____ Medical Records (general health care) Date range __________ Initial here ________

____ HIV test results or other tests for sexually transmitted diseases Date range __________ Initial here ________

____ Counseling Summary Date range __________ Initial here ________

____ Other specific reports __________________________ Date range __________ Initial here ________

The purpose for this release of information is as follows: At my request – signature below **or** as follows:

____

This Authorization will be in effect for the current academic year as indicated by your dated signature below. You may withdraw or revoke this authorization to release information by writing at any time to the Director of the Center for Health and Counseling, but the Center may continue to rely on this authorization to the extent that services have already been provided based on this authorization. Please also note that the Center for Health and Counseling cannot control how the information released through this authorization will be used or whether it will be re-released or re-disclosed by the recipient of the information without further authorization from you.

Name (print) __________________________________Date of Birth ___________ Student I.D.______________

Address____ Phone _________________________

____ ____

Signature of student Date Witness/UAF staff person Date

____ ____

Signature of student's parent or representative Date Relationship to student

Revised: 4/1/2011