STUDENT HEALTH AND COUNSELING CENTER
University of Alaska Fairbanks

1007 N. Chandalar Dr. | P.O. Box 755580
Fairbanks, AK 99775
Ph: 907-474-7043 | F: 888-837-2146
www.uaf.edu/chc | uaf-sh-cc@alaska.edu

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name:_____ Date of Birth:_____
Student ID #: _____ Phone #: _____
Physical Address: _____

I HEREBY AUTHORIZE THE DISCLOSURE AND USE OF MY HEALTH INFORMATION: [CHECK AS APPROPRIATE]

O From O To O Both (Two-way) O From O To O Both (Two-way)

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Name: _____
Street Address: _____
City, State, Zip: _____
_____
Phone:_____Fax:_____

Dates of Records/ Information to be Released: From:_____To:_____or All:_____

TYPES OF RECORDS/INFORMATION
[Check as appropriate]

- ☐ All medical records
- ☐ Immunization record(s) and test results
- ☐ Lab result(s)
- ☐ Psychological testing reports
- ☐ X-ray or other diagnostic test reports
- ☐ Other (please specify) _____

The following items must be initialed by you if you desire these records to be released:

STI : _____
Genetic testing: _____
HIV/AIDS: _____
Substance or alcohol use/abuse: _____
Counseling visit notes *may require consult with counselor*):_____

Your record may include information from another health care provider or entity.
I authorize the release of these records. Initial Here _____

Method of Disclosure : Mail____Fax____In Person____Secure Email_____
Purpose of Disclosure (optional): Personal ____Health care____Legal____Parent/Guardian____Insurance____
Other_____
EXPIRATION: This authorization will expire in one year unless otherwise noted here Initial Here_____

Re-disclosure: I understand that when the information is disclosed pursuant to this Authorization to someone who is not required to comply with the federal or state privacy protection requirements, it may be subject to re-disclosure by the recipient and may no longer be protected.
Revocation: I understand that I may revoke this Authorization at any time by writing to the address above. A request to revoke my authorization will not apply to the extent that SHCC has taken action in reliance upon this authorization.
Condition of Eligibility: Signing this release will not condition your treatment, payment, enrollment or benefit eligibility at the SHCC.

_____ _____
Signature of student or other authorized person Printed name of other authorized person Date

The Student Health and Counseling Center reserves the right to authenticate patient signatures on forms received by fax or mail prior to the release of requested information.