UNIVERSITY OF MARYLAND
UNIVERSITY HEALTH CENTER
Accredited by the Association for Accreditation for Ambulatory Health Care

University Health Center
Building 140, Campus Drive
College Park, Maryland 20742
301.314.8180 TEL 301.405.9755 FAX

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

PATIENT INFORMATION

Last Name	**First Name**
UID Number	**Date of Birth (MM/DD/YYYY)**
Phone Number	**Today's Date (MM/DD/YYYY)**
Street Address	**City, State, and Zip Code**

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

☐ FROM ☐ TO	☐ FROM ☐ TO
University Health Center **University of Maryland** 3983 Campus Drive College Park, MD 20742 Phone: 301-314-8180 Fax: 301-405-9755	Name: _____ Title/Relationship: _____ Department (IF APPLICABLE): _____ Street Address: _____ City, State, and Zip Code: _____ Phone: _____ Fax (IF PREFERRED METHOD OF DELIVERY): _____ Email (IF PREFERRED METHOD OF DELIVERY): _____

METHOD OF DISCLOSURE: [CHECK AS APPROPRIATE]

☐ Mail ☐ Fax ☐ In-Person Pick-up by Patient ☐ Verbal ☐ Encrypted Email

Please Note:

1. Fax and email may compromise your privacy.
2. The UHC charges the following rates for copying:
   - 1-5 pages: No charge
   - 6-10 pages: $5
   - 11-15 pages: $10
   - 16-20 pages: $15
   - 20 or more pages: $20
   - Copying more than one chart: Additional $15
3. The UHC reserves the right to authenticate the patient's signature on forms received by fax or mail prior to the release of the requested information.
4. This form can be faxed, mailed, or uploaded securely to the Patient Portal (myUHC.umd.edu). The mailing address and fax number are located on the upper right-hand corner of this form.
5. Please allow 3-5 days for processing after your form has been submitted.
6. This Authorization applies ONLY to the information indicated above, and information will be sent ONLY to the above address, fax number, or encrypted email address. Additional information or disclosure to another person or entity or another address, fax number, or encrypted email address will require another Authorization.

PURPOSE OF AUTHORIZATION: [CHECK ONE]

☐ Personal Use ☐ Patient Care ☐ Legal ☐ Parent/Guardian Communication ☐ Insurance
☐ Other: _____

EXPIRATION OF AUTHORIZATION

This Authorization will expire on: _____
[Insert defined event or date not later than one year from the date the Authorization is signed]

Last Name: _____ First Name: _____ UID: _____

REQUESTED RECORD INFORMATION

Dates of Record Information	**From (MM/DD/YYYY)**	**To (MM/DD/YYYY)**
Types of Records [CHECK AS APPROPRIATE]	☐ Entire Medical Record ☐ Statement for Insurance Claims and other Billing Purposes *(Please be advised that the UHC does not send this to insurance companies)* ☐ Behavioral Health Record(s) ☐ Drug Testing Result(s) ☐ Immunization Record(s)	☐ Lab Result(s) ☐ Radiology Report(s) ☐ Physical Therapy Record(s) ☐ Prescription/Pharmacy Record(s) ☐ Reproductive/Gynecological/Sexual Health Record(s) ☐ Other: _____
My initials authorize the inclusion of the following types of sensitive information pertaining to:	_____ Abuse* (Sexual/Physical/Mental) ***UHC employees are mandated reporters of child abuse** _____ Behavioral Health _____ Drug/Alcohol Use/Abuse _____ Drug Testing _____ Genetic Testing	_____ Pregnancy/Miscarriage/Abortion _____ Reproductive/Sexual Health _____ Sexually Transmitted Infections _____ HIV/AIDS _____ Other Reportable Diseases ***Healthcare providers are mandated reporters of communicable diseases to the health department**
If the information includes records or information from another healthcare provider or entity, that information: [CHECK ONE]	☐ **should** be released under this Authorization.	☐ **should not** be released under this Authorization.

PATIENT ACKNOWLEDGEMENT – PLEASE READ CAREFULLY

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 further understand that I retain the right to revoke this Authorization at any time if I do so in the manner set forth below. I understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my PHI have already acted in reliance on this Authorization. In order for my revocation to be effective, it must be in writing. The revocation must include:

- The patient's name, address, and identification number, if applicable.
- Sufficient information to identify this Authorization including the date and recipient of PHI.
- The patient's desire to revoke this Authorization;
- The intended date of the revocation, if later than the receipt of the revocation; and
- The patient's signature.

ALL revocations must be sent in writing to the entity releasing the PHI at the address provided above. A revocation is not effective until the later of the date it is received by the entity or any other date specified in the revocation.
The University Health Center will accept written revocations of this Authorization, sent to the attention of the Medical Records Supervisor via: (1) Hand Delivery, (2) Certified US Mail, or (3) Facsimile at 301-405-9755.

Inspect and Copy: I understand that I have the right to inspect or copy my PHI to be used or disclosed pursuant to this Authorization, as permitted by law.

Conditioning Treatment, etc.: I understand that the University Health Center will not condition my treatment, enrollment in a health plan, or eligibility for benefits on whether I provide Authorization for a requested use or disclosure except in limited circumstances, such as certain research-related treatment or health care solely for the purpose of providing information to another person or entity.

I AUTHORIZE THE USE AND/OR DISCLOSURE OF MY PHI AS DESCRIBED ABOVE. I HAVE READ THE CONTENTS OF THIS AUTHORIZATION, AND I FULLY UNDERSTAND AND ACCEPT ITS TERMS.

Patient or Personal Representative Signature	**Date of Signature**
Printed Name of Personal Representative	**Relationship to Patient**

FOR INTERNAL OFFICE USE ONLY

Authorization verified and added to the patient's medical record: By _____ On: _____
Copy of Authorization given to the patient (if applicable): By _____ On: _____
PHI Authorization Disclosures (date and recipient) must be documented in the patient's medical record.
Revocation Received: By _____ On: _____
Statement and/or information mailed/faxed/emailed to patient/parent/other: By _____ On: _____