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 Name: _____ UID: _____

Phone Number: _____ Date of Birth: _____

Mailing Address: _____ Today's Date: _____

_____

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

☐ **FROM** or ☐ **TO**

**University of Maryland**
**University Health Center**
Bldg 140 Campus Drive
College Park, MD 20742
Phone: 301-314-8180
Fax: 301-405-9755

☐ **FROM** or ☐ **TO**

Name: _____
Street Address: _____
_____
City, State, Zip:
_____
Phone: _____
Fax: _____
*IF PREFERRED METHOD OF DELIVERY*

☐ **FROM** or ☐ **TO**

Title: _____
Department: _____
Work Phone: _____
Fax: _____
*IF PREFERRED METHOD OF DELIVERY*

☐ **FROM** or ☐ **TO**

Title: _____
Department: _____
Work Phone: _____
Fax: _____
*IF PREFERRED METHOD OF DELIVERY*

**DATES OF RECORDS/INFORMATION**
**FROM:** ___/___/___ **TO:** ___/___/___

**TYPES OF RECORD(S) INFORMATION** [Check as appropriate]

- ☐ Statement, for Insurance Claims and other Billing Purposes *(Please be advised that the UHC does NOT send this to insurance companies)*
- ☐ Entire Medical Record
- ☐ Lab Result(s)
- ☐ X-Ray Report(s)
- ☐ Immunization Record(s)
- ☐ Prescriptions/ Pharmacy Record(s)
- ☐ Physical Therapy
- ☐ Women's Health Record(s)
- ☐ Mental Health Record(s) *(except psychotherapy notes)*
- ☐ X-ray(s)
- ☐ Hospital Record(s)
- ☐ Other (please specify): _____

**My initials below authorize inclusion of the following types of sensitive information pertaining to:**

Drug/Alcohol Use/Abuse: _____ HIV/AIDS: _____ Sexually Transmitted or other reportable diseases: _____

Genetic Testing: _____ Mental Health: _____ Abuse* (Sexual/Physical/Mental): _____

Pregnancy/Maternity: _____ Abortion: _____

** UHC employees are mandated reporters of child abuse.*

If the information includes records or information from another health care provider or entity, that information:
[Check one] __ **should** or __ **should not** be released under this Authorization.

**Please Note:** This Authorization applies ONLY to the information indicated above, and information will be sent ONLY to the above address or fax number. Additional Information or disclosure to another person or entity or another address or fax will require another Authorization.

**METHOD OF DISCLOSURE**
Please release my records/information via: [Check as appropriate]
__ Mail __ Fax __in person pick-up by patient __Verbal

**Please Note:**
1. Faxing may compromise your privacy.
2. The University Health Center charges for copying as follows:
   1-5 pages, No Charge; 6-10 pages, $4; 11-15 pages, $6; 16 pages or more, $20; and an additional $15 for copying more than one chart.

**Revised: 7.22**

**PURPOSE OF AUTHORIZATION**

**The authorization is for the following purpose:** [Check one and complete as needed]

__Personal Use __Patient Care __Legal __Parent/Guardian Communication __Insurance

Other:_____

**EXPIRATION OF AUTHORIZATION**

[Insert defined event or date not later than one year from the date Authorization is signed]

**This Authorization will expire on:** _____.

## 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 dis-close 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 identity this Authorization including 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:

- Hand Delivery
- Certified US Mail
- 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**

_____ _____

Print Name of Personal Representative Relationship to Patient

**PLEASE NOTE:**

- The Health Center reserves the right to authenticate patient signature on forms received by fax or mail prior to the release of requested information.
- This form can be faxed, mailed, or uploaded securely through **myuhc.umd.edu.** Mailing address and fax number are located on the upper right hand corner of this form.
- Please allow 3-5 days for processing after your form has been submitted.

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***FOR INTERNAL OFFICE USE ONLY***

Authorization verified and added to the patient's medical record: By_____ On: _____

Copy of Authorization given to patient, if applicable: By_____ On: _____

**Disclosures made in response to Authorization (PHI), (date and recipient) are to be documented in the patient's medical record.**

**Revocation Received:** _____

**Statement and/or information mailed/faxed to parent/student/other:** By_____ On: _____