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Birmingham, AL 35229-2452
Phone: 205.726.2835
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Authorization for Release of Information

Patient Name: Last First M.I.

Address:

Phone Number: () - Date of Birth:

Student ID Number:

This Authorization applies to the following information:

All information. I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, AIDS/HIV information, and/or other sensitive health information and I expressly consent to the release of the information.

Only the following records or types of information:

Treatment Dates:(month/date/year) from to

The information may be released from Samford University Student Health Services to: (Please provide name/and mailing address or fax number)

Purpose of the release: Continuity of Treatment Other (Please specify)

I understand the information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of information to a recipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 (HIPPA), then the recipient may re-disclose it and it may no longer be protected under HIPPA, a federal privacy law. This Authorization is valid for ninety (90) days from the date of signature, unless otherwise noted. This Authorization only applies to treatment occurring before the date of signature. I may decline to sign this Authorization. I understand I may revoke this authorization in writing at any time by completing a form available from Samford University Student Health Services. If I revoke this authorization, the revocation will not apply to information that has already been released in response to this authorization. I understand the patient's health care and the payment for the patient's health care will not be affected if I do not sign this form. I understand I may see and copy the information described on this form if I request it, and I may receive a copy of this form after I sign it. I represent that I have the authority to and voluntarily grant permission for the information to be released as described above.

Patient Printed Name Date

Patient Signature Date

Witness Signature for Patient Date