

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)**

I. Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_  
ID Number \_\_\_\_\_ Phone Number \_\_\_\_\_  
Please check one: Current NCSU Student \_\_\_\_\_ Dates Enrolled \_\_\_\_\_  
Former NCSU Student \_\_\_\_\_ Dates Enrolled \_\_\_\_\_

II. Please check one and provide the requested information:

\_\_\_\_\_ I hereby authorize my NCSU Medical Provider to disclose my Protected Health Information to the following organization(s) and/or person(s):

Name \_\_\_\_\_  
Address \_\_\_\_\_  
(City) (State) (Zip Code)  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

\_\_\_\_\_ I hereby authorize \_\_\_\_\_  
(Primary Care Physician or Other Health Care Provider) (Phone Number) (Fax Number)  
\_\_\_\_\_ to disclose my Protected Health Information to NCSU Student Health Services.  
(Address)

III. I authorize the following information to be disclosed:

CHECK ONE	DATE(S) OF SERVICE	
_____	_____	Immunizations, including immunization records from other providers
_____	_____	Complete Medical Record, including records from other providers
_____	_____	Complete Medical Record while at NC State, not including records from other providers
_____	_____	GYN (Pap, Pelvic, Lab)
_____	_____	Lab
_____	_____	X-ray
_____	_____	Other or Relating to Particular Problem _____

\_\_\_\_\_ To verbally release information re: medical services, itemized statements, billing change information.

IV. Purpose of the Requested Disclosure: Please check one and provide the requested information.

\_\_\_\_\_ At the request of the patient. \_\_\_\_\_ OR \_\_\_\_\_  
(Patient's initials) (State specific purpose of requested disclosure)

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter provided to the Director of Student Health Services or the other provider to whom this permission to release is granted. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my Protected Health Information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that NCSU Student Health Services may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I further understand that if the persons(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by federal privacy regulations.

I agree that a copy of this release or fax of this release shall be as valid as this original release. If I authorize NC State to fax the information, I realize there are inherent risks in faxing Protected Health Information. I understand a fee will be charged to cover the costs of copying, including the cost of supplies and labor of copying and mailing Protected Health Information released to anyone other than another health care provider. I understand I will get a copy of this form after I sign it.

This authorization expires in one year or \_\_\_\_\_  
(Specify date, if less than one year)

\_\_\_\_\_  
Signature of Patient or Patient's Representative Date

\_\_\_\_\_  
Printed Name of Patient's Representative Relationship to Patient