

Old Dominion University
Yon Student Health Services
1007 Webb Center, South Wing
Norfolk, Virginia 23529
Phone (757) 683-3132; Fax (757) 683-5930

RECORDS RELEASE AUTHORIZATION

PATIENT NAME: _____
UIN: _____
DOB: _____
PHONE: _____

THE UNDERSIGNED AUTHORIZED AND REQUESTS:

(Healthcare Provider or Facility)

(Address, Phone or Fax)

TO PROVIDE TO:

(Agency Receiving Information)

(Address, Phone or Fax)

FOR THE PURPOSE OF: _____
FOR THE TIME PERIOD OF: _____

INFORMATION TO BE RELEASED:
_____ HISTORY AND PHYSICAL EXAM _____ PROGRESS NOTES
_____ LAB DATA/TEST RESULTS _____ X-RAY/EKG
_____ HIV TEST RESULTS OTHER _____

I understand that my health information may include information related to sexually transmitted diseases, mental health services or treatment for drug and alcohol abuse.
This consent will automatically revoke 180 days from the date it was signed or on _____.

SIGNATURE: _____ DATE: _____
WITNESS: _____ DATE: _____

PROHIBITION OF REDISCLOSURE: This information has been disclosed from records protected by Federal Confidentiality Rules "42 CFR Part 2." The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by "42 CFR Part 2." A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

J: SHC/HIM/Forms: 5/08

Request completed by _____ Date completed _____ ROI Log _____