Authorization to Release / Obtain Protected Health Information

Commonwealth University: Bloomsburg
Student Health Center
Room 324 Kehr Union Bldg.
400 E. Second Street
Bloomsburg, PA 17815

(570)389-4451 (Office)
(570)389-3417 (Secure Fax)

Legal Name:	Birth Date (mm/dd/yyyy):
Student ID Number:	Primary Campus:
Student E-mail:	Student Phone Number:

I authorize the Commonwealth University: Bloomsburg Student Health Center to ☐ Release to ☐ Obtain from

Name of Individual/Agency:	Phone Number:
Address:	E-Mail:
City, State, and Zip	Fax:

The specific information to be disclosed/received from _____ through _____ includes:

		Date		**Date**
	Any & All Information		Laboratory tests and Radiology reports
	Immunization records/dates		Tuberculosis (TB) test results
	Clinic Notes		Other (specify):

For the purpose of:

	Family/Guardian Communication		Coordination of Care/Treatment
	CARE team discussion		Other (specify):

This authorization is intended to allow the Commonwealth University student health services to release information, both written & verbal, in the best interest of the patient. This release demonstrates compliance with Family Educational Rights and Privacy Act (FERPA) treatment records and personally identifiable information (PII)- 20 U.S.C. 1232g(a)(4)(B); 34 CFR 99.3

This authorization may be revoked at any time by submitting a written request, except to the extent that the information has already been disclosed in reliance on this authorization.

I understand that my diagnosis and treatment for drug/alcohol treatment, HIV/AIDS and Mental Health/Rehabilitation may be released to and/or obtained from the agency/individual listed above.
*** Only** initial if you do **NOT** want to release information relating to: ___ Drug/Alcohol ___HIV/AIDS ___Mental Health/Rehabilitation

This consent will expire one (1) calendar year from the date of signature, unless revoked by written request earlier.

_____ _____ _____ _____
Individual Signature Date Time Witness Name and Signature Date Time

VERBAL CONSENT: If the patient is unable to provide a physical signature, document the date and time of verbal authorization. Two responsible persons must sign below to witness that the individual understands the nature of the authorization and freely gives verbal authorization.

_____ _____ _____ _____
1st Witness Name/Signature Date & Time 2nd Witness Name/Signature Date & Time

IMPORTANT INFORMATION ABOUT THESE RECORDS TO RECIPIENT: This information has been disclosed to you from records whose confidentiality has been protected by PA state law. State regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains.

OFFICE USE ONLY Records Sent/Released: Date _____ Initials _____ SOP: Release of Information form 08.23