University of Central Florida

University of Central Florida- Health Services
P.O. Box 163333, Orlando, FL 32816-3333
Tel (407) 823-2091, Fax (407) 823-3359
Health Information Management - Authorization Form **Revised: 02/09**

I, _____, hereby authorize the use or disclosure of my individually identifiable health information as specified below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

☐ **Entire Medical Record:** _____
☐ **Office Visit:** List date of visit: _____
☐ **Lab Result**: List test(s) or date(s): _____
☐ **X-ray Results of Films**: List date or images _____
☐ **Immunization Records:** O All or O Specific Immunization _____
☐ **GYN Records:** O All or O Specific date or lab _____
☐ **Other:** _____

The listed information below will only be released if the **INCLUDE** related square is checked.
If you **do not want** this information released, you must check the related **EXCLUDE** square.

INCLUDE	EXCLUDE		INCLUDE	EXCLUDE	
☐	☐	**HIV and/or AIDS**	☐	☐	**STD**
☐	☐	**Drug Abuse**	☐	☐	**Alcohol Abuse**
☐	☐	**Psychiatric Records**	☐	☐	**Sexual Assault Records**

Format: ☐ **Pick up** ☐ **Mail** ☐ **Fax** ☐ **Telephone** ☐ **Consent to discuss in person**

I authorize this release of information to:

☐ **Self** (List current address and phone number)

Name: _____

Address: _____

Phone: _____

☐ **Other** (List name, address and phone number)

Name: _____

Address: _____

Phone: _____ Fax: _____

- I understand that I may ask and get a copy of this authorization after I sign it.
- I understand that this authorization will expire 90 days from date signed unless otherwise specified.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any affect on any actions UCF Health Services took before they received the revocation.

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____ Univ. ID or last 4 digits of SS# _____

_____ _____
Signature of Parent or legal Guardian (when applicable) Date

_____ _____
Witness Name & Signature Date

Cancellation of Authorization

I, _____, would like to cancel this authorization as of: _____

Signature to Cancel: _____ Cancellation Date: _____

*******CONFIDENTIALITY NOTICE*******

The documents accompanying this telecopy transmission contain confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you received this telecopy in error, please notify the sender immediately to arrange for return of these documents.

NB: Any request not made in person must be notarized by a Notary Public and mailed to UCF Health Services above address.

Copied/Sent By: _____ On: _____ Faxed By: _____ On: _____ Hand Carried By: _____ On:_____