Student Name: ____
Phone Number: ____________________ **Date of Birth:** ________________ **UAF ID#:** _______________
Mailing Address: ____
Today's Date:________________

I HEREBY AUTHORIZE THE DISCLOSURE AND USE OF MY HEALTH INFORMATION: [CHECK AS APPROPRIATE]

o **From** o **To** o **Both (Two-way)**
UAF Student Health and Counseling Center
1788 Yukon Drive
Fairbanks AK 99775
Phone: 907-474-7043
Fax: 907-474-5777

o **From** o **To** o **Both (Two-way)**
Name: ___________________________________
Street Address: ____________________________
City, State, Zip: ____________________________
____
Phone: ___________________________________
Fax:_____________________________________

DATES OF RECORDS/INFORMATION TO BE RELEASED From: ___________ To: __________ or All:_____________

TYPES OF RECORDS/INFORMATION
[Check as appropriate]

o All medical records
o Immunization record(s)
o Lab result(s)
o Psychological testing reports
o X-ray or other diagnostic test reports
o Other (please specify) __________________

The following items must be initialed by you if you desire these records to be released:

Sexually transmitted diseases:_______
Genetic testing: ________
HIV/AIDS:_______
Substance or alcohol use/abuse: _______
Counseling visit notes (psychotherapy notes-release *may require consult with counselor*):_______

If our records include records or information from another health care provider or entity, that information:
[Check one] o should or o should not be released under this Authorization.

METHOD OF DISCLOSURE: Mail____ Fax____ In person___ Verbal___

PURPOSE OF DISCLOSURE (optional): Personal Use____ Health care____ Legal____ Parent/Guardian____ Insurance____ Other____

EXPIRATION OF AUTHORIZATION:
This authorization will expire in **one year** unless otherwise noted here:______

Re-disclosure: I understand that when the information is disclosed pursuant to this Authorization to someone who is not required to comply with the federal or state privacy protection requirements, it may be subject to re-disclosure by the recipient and may no longer be protected.
Revocation: I understand that I may revoke this Authorization at any time by writing to the address above. A request to revoke my authorization will not apply to the extent that SHCC has taken action in reliance upon this authorization.
Conditioning of Eligibility: SHCC will not condition treatment, payment, and enrollment or benefit eligibility on my signing this document.

_____________________________________ ___________________ ________________________________
Signature of student or other authorized person Date Printed name of other authorized person (if used)