SHC

STUDENT WELLNESS CENTER
Student Health Center
4505 Maryland Parkway
Box 453020
Las Vegas, Nevada 89154-3020
(702) 895-3370 · FAX (702) 895-4316

UNLV
UNIVERSITY OF NEVADA LAS VEGAS

Account No.

AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION
(For purposes other than treatment, payment or health care operations)

It may *take 5 business days and no more than 30 days* to process your request. Cost of copies is $.60 per page. A copy of authorization is available upon request.

Name: _____ **DOB:** _____ **NSHE #:** _____

Phone No. to contact you: _____

I HEREBY AUTHORIZE INFORMATION TO BE RELEASED:

FROM:	**TO:**
Name/Agency: _____	**Name/Agency:** _____
Address: _____	**Address:** _____
_____	_____
Ph. No. _____ **Fax No.** _____	**Ph. No.** _____ **Fax No.** _____

☐ **Allow mutual disclosure between agencies listed above**

PURPOSE FOR RELEASE: _____

INFORMATION TO BE RELEASED:

_____ Last pap report
_____ Last GYN physical exam
_____ Office/Consult Notes
_____ Mental Health Evaluation/Treatment
_____ Entire Health Record

_____ Lab reports (specify) _____
_____ Immunizations (specify) _____
_____ X-ray reports (specify) _____
_____ Other: (specify) _____

SPECIFIC AUTHORIZATION: I understand that the information in my health record MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information.
DO NOT INCLUDE INFORMATION STATED ABOVE. _____ (Initials).

This authorization is effective immediately and is subject to revocation in writing at any time, except to the extent that action has already been taken in reliance thereon. Otherwise, this authorization ***expires one year from date of signature.***

The confidentiality of medical, psychiatric and substance abuse information is protected by State and Federal Statutes, Rules and Regulations including Nevada Revised Statutes and Title 42 of the Code of Federal Regulations. These Statutes, Rules and Regulations require that the individual give informed consent prior to the release of any health/hospital records or information, except as specifically provided for within the Statutes, Rules and Regulations. I understand if I do not authorize the release of my full health record, the recipient will be notified that only a limited health record is provided per patient request. Provider will not require me to sign an authorization as a condition of further treatment. I understand that the information used or disclosed pursuant to this authorization should not be re-disclosed without the written authorization of the student. The university, the Student Wellness Center (Student Counseling and Psychological Services and Student Health Center), its employees, officers, and healthcare providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Student or Legal Representative: _____ **Date**: _____

Print Name of Legal Representative: _____ **Phone No.** _____

Relationship to student: □ Parent □ Legal Guardian (Attach documentation of guardianship)

Date Disclosed:_____ PHI Sent to Requestor Via: ☐ Fax ☐ Mail ☐ Pick Up Box ☐ Given to Patient

Pages Prepared:_____ Type of PHI Disclosed: _____

PHI Xeroxing Charges: $ Staff Initials & Title:

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