

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



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

Please be advised that it may take 5 business days and no more than 30 days for your request to be processed. A copying fee of \$.60 per page applies to your request per NRS 629.061. Also, a copy of this authorization is available upon request.

**PLEASE PRINT CLEARLY:**

<b>Name:</b>	<b>Date of Birth:</b>	<b>Student ID No:</b>
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I hereby authorize: (Name & address of place releasing information) \_\_\_\_\_ To release health information to: (Place / person receiving information) \_\_\_\_\_


Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_ Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

**Specify Date(s) of Treatment at SHC to Be Released:** \_\_\_\_\_

**Disclosure of:**  Last Pap Report  Last GYN Physical Exam  Progress Office Notes (specify dates) \_\_\_\_\_

Immunizations (specify) \_\_\_\_\_  Lab test (specify test) \_\_\_\_\_

Other (specify type of information): \_\_\_\_\_

Entire Health Record:  **I understand that releasing my entire health record may include information relating to:**

	(Initials)	(Initials)
<input type="checkbox"/> AIDS or HIV infection	_____ release	_____ do not release
<input type="checkbox"/> Psychiatric care	_____ release	_____ do not release
<input type="checkbox"/> Treatment for alcohol and / or drug abuse	_____ release	_____ do not release

**Released of Information may be:** (Please initial) \_\_\_\_\_ Verbal \_\_\_\_\_ Written \_\_\_\_\_ Faxed \_\_\_\_\_

**Purpose of Release:**  Continuity of Care  Consultation  School Transfer  Personal  Insurance

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 my further treatment except where the treatment is for the purpose of research or solely for the purpose of creating a health record for disclosure to a third party and I refuse to authorize such disclosures.

I understand I may revoke this authorization in writing at any time, except to the extent that action has been taken place. Forms are available upon request. This authorization **will expire 90 days from date of signature** and I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient. The University, the 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 Patient or Legal Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient  Parent  Legal Guardian (specify & attach documentation): \_\_\_\_\_

PHI Disclosed on: _____	PHI Sent to Requestor Via: <input type="checkbox"/> Fax <input type="checkbox"/> Mail	PHI In Pick Up Box _____
No. of PHI Pages Prepared: _____	Type of PHI Disclosed: _____	
PHI Xeroxing Charges: \$ _____	Staff Initials & Title: _____	