# Authorization to Release and/or Disclose Health Information

***HEALTH INFORMATION OF:***

Patient's Name: _____ Local Telephone: _____

Local/ Home Address: _____ City/State/Zip Code _____

Banner ID or SSN: _____ DOB: _____

Purpose for Request (Please Check) ☐ Work ☐ School ☐ Personal ☐ Legal ☐ Other _____

Delivery method: FAXED ☐ MAILED ☐ IN PERSON ☐

**I hereby authorize the release of medical information:**

| ☐ To (Please Check One) ☐ From | ☐ To (Please Check One) ☐ From |
|---|---|
| **North Carolina A & T State University**<br>Alvin V. Blount, Jr.<br>Student Health Center<br>1601 E. Market Street<br>Greensboro, NC 27411<br>(336) 334-7880 office (336) 256-2613 fax | _____<br>(Name)<br>_____<br>(Street)<br>_____<br>(City, State, Zip Code)<br>_____<br>(Telephone) (Fax) |

***SPECIFY INFORMATION TO BE OBTAINED:***

| | | |
|---|---|---|
| ☐ Discharge Summary | ☐ Progress/Physician Notes | ☐ X-Ray Report |
| ☐ Pathology Report | ☐ Physical Examination | ☐ Emergency Report |
| ☐ EKG/EMG /EEG | ☐ Consultation Report | ☐ Immunization Records |
| ☐ Laboratory Report | ☐ Women Health Notes | ☐ Depo / Rx Notes |

☐ Other _____

**Record for the period (dates) from _____ to _____**

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization to the extent allowed by law.

TERM: I understand that I may revoke this authorization at any time except to the extent that action has been taken on this authorization. Unless otherwise revoked, this authorization will expire on the following date: _____ . If no express revocation is issued, this authorization will expire in **(90)** days from the date of signature.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Signature of Witness **Date**