

**EAST CAROLINA UNIVERSITY
HEALTH CARE COMPONENTS**

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Authorization for Use or Disclosure of Protected Health Information

I authorize (Name of Health Care Component or Provider) _____

_____ to use or disclose a copy of the specific health information identified

below for (Name, Birth Date, and Banner ID Number of Patient)

_____ to (Name and Complete Address & Phone of Receipt) _____

The purpose of this is for (Describe Each Purpose for Your Request of Use or Disclosure)

Delivery Method: (Please check one.) Will pick up copies. Mail to the above address Fax

FAX Number: _____

By initialing the spaces below, I specifically authorize the use or disclosure of the following health information created and maintained by a Health Care Component of East Carolina University (ECU):

- | | |
|--|---|
| <input type="checkbox"/> Entire Medical Record , Date(s) _____ | <input type="checkbox"/> Lab Reports, Date(s) _____ |
| <input type="checkbox"/> Pathology Reports, Date(s) _____ | <input type="checkbox"/> Radiology Reports, Date(s) _____ |
| <input type="checkbox"/> Clinic Notes, Date(s) _____ | <input type="checkbox"/> Dental Records, Date(s) _____ |
| <input type="checkbox"/> Billing Statements, Date(s) _____ | <input type="checkbox"/> Other _____ |

The following items must be initialed to be included in this request for use or disclosure:

- | | |
|--|--|
| <input type="checkbox"/> HIV/AIDS related information ____ | <input type="checkbox"/> Genetic testing information ____ |
| <input type="checkbox"/> Mental health information ____ | <input type="checkbox"/> Drug & Alcohol treatment information ____ |

I understand that, if the person or organization receiving this information is not a health care provider, health care organization, or health plan covered by federal privacy regulations, then this information may be redisclosed and no longer be 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.

I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken upon this authorization. Unless revoked earlier, this authorization to use or disclose your health information will expire in 90 days. **(Enter Date)** _____ or **(Specific Event, i.e., sending as requested above)**

Mail Back To:
[ECU Student Health Service, East 5th Street, Greenville, NC 27858]

Please forward any requests to revoke a previously signed authorization to:

Privacy Official
Brody School of Medicine at East Carolina University
600 Moyer Blvd
Lakeside Annex 2
Greenville, NC 27858

Finally, I have read and understand this information. I have received a copy of this form if the request for use or disclosure is being made by a Health Care Component of ECU. I am the patient or I am authorized to act on behalf of the patient to sign this document authorizing the use or disclosure of Protected Health Information under the above terms.

Date: _____

Signature of Patient

Please Print Name

Patient's Contact Phone Number

Person Signing of Behalf of Patient

Please Print Name

Internal Use Only Patient Medical Record # _____

Last Enrollment at ECU Semester _____ Year _____

Copy sent as requested on (include detail of information): _____

By:

Signature Title/Location Date