UVU STUDENT HEALTH SERVICES
UTAH VALLEY UNIVERSITY

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ Student ID: ________________

Date of Birth: ______________________ Phone#: __________________________

Approximate Dates of Treatment: ____

Purpose of the requested use or disclosure:

☐ Continued Care and Assessment
☐ Personal Use
☐ Legal Purposes
☐ Other (Specify): ____________________

Release Protected Health Information FROM:

☐ UVU Student Health Services
800 W. University Pkwy MS200
Orem, UT 84058
Fax: 801-863-7056
Phone: 801-863-8876

☐ Other Medical Office or Entity:
Facility: __________________________
Medical Professional: ________________
Individual: _________________________
Phone: ____________________________
Address: ___________________________
____
Fax: ______________________________

Release Protected Health Information TO:

☐ UVU Student Health Services
800 W. University Pkwy MS200
Orem, UT 84058
Fax: 801-863-7056
Phone: 801-863-8876

☐ Other Medical Office or Entity:
Facility: __________________________
Medical Professional: ________________
Individual: _________________________
Phone: ____________________________
Address: ___________________________
____
Fax: ______________________________

☐ Yourself
Address: ___________________________
____

Please include the following information:

☐ Lab Report
☐ Immunizations
☐ History/Physical
☐ Psychosocial History
☐ Treatment Plans
☐ LD Testing Report
☐ Other:____

I understand that the medical records released pursuant to this authorization could contain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious diseases which are subject to federal and/or state disclosure restrictions. By my signature below, I specifically authorize the disclosure of those records. I also 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.

This permission to disclose my protected health information is valid for a period on ONE (1) year, or until ______________________, 20___, whichever occurs first. I understand that I can change my mind and cancel or revoke this permission at any time by sending a letter to UVU Student Health Services at the address given above. That revocation shall include all but the information that has already been disclosed or released pursuant to this authorization and prior receipt of the revocation. I hereby affirm that I have read and fully understand the statements above and consent to the disclosure of the protected health information for the purpose and extent stated.

Signature of Patient or Legally Authorized Representative: ______________________________

Relationship to Patient: ______________________________ Date: ____________________