Plymouth State UNIVERSITY

HEALTH SERVICES
16 Merrill Street, Plymouth, NH, 03264
phone (603) 535-2350, fax (603) 535-3291

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize, Health Services to use/disclosure my individually identifiable health information as described below. If I do not want this information sent I must initial below. I understand that this authorization is voluntary and I may refuse to sign this authorization.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or health care provider, the released information may no longer be protected by the federal and state privacy regulations.

Patient Name _____ DOB_____ Phone number_____

Address _____

Description of the purpose of the use and/or disclosure: (please check one)

Moving ☐ Changing Provider ☐ Second Opinion ☐ Consultation ☐

Insurance Change ☐ Accounting of Disclosure of my PHI ☐

Other (please describe) _____

Information to be disclosed:

Related dates: _____

Office notes ☐ Lab reports ☐ Xray reports ☐ Other test reports ☐

Immunizations ☐ Photographs or other Images ☐ Disclosures of my PHI ☐

Other _____

The health information described herein shall be released to (please check one):

Outside Provider ☐ Insurance Company ☐ Attorney ☐

Patient Friend or Family member ☐ Other ☐

Name _____ Address _____

City_____ State _____ Zip Code_____

Phone number _____ Fax number _____

I understand that this authorization is valid for 12 months after the date signed, unless I otherwise specify. I further understand that I may revoke this authorization at any time by notifying Health Services in writing. This written revocation must be signed and dated with a date that is later than the date of this authorization.

_____ _____

Signature of Patient or Personal Representative *Date*