FELICIAN UNIVERSITY

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Authorization for Use or Disclosure of Health Information

*Print Patient Name____*DOB:___________________

*Maiden name if married_______________________________ *Last 4 digits of SSN#_____________________________

*Address: ____

Phone:___________________________ Date last attended Felician University: _________________________________

I hereby authorized the use and disclosure of individually identifiable health information relating to me as described below:
[] Physical Exam [] Immunizations [] PPD [] Lab Work [] Other (describe) _____________________________________

The above information will be called "Authorized Information" throughout the rest of this form.

Persons authorized to make the Use or Disclosure of Authorized Information:

___________________Felician University Center for Health__________________

*__Persons to Whom the Use or Disclosure of Authorized Information may be made:__

____

*__Purpose for Use or Disclosure of Authorized information (new school, new job, etc.):__

____

□ I understand that if the person or entity receiving Authorized Information is not a health plan or health care provider covered by the federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be protected by the federal or state law.

□ I understand that I may revoke this authorization at any time by notifying the Center for Health in writing. However, if choose to do so, I understand that my revocation will not affect any actions taken by the Center for Health before receiving my revocation.

□ I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, and enrollment in a health plan or eligibility for benefits.

This authorization will be effective until it expires on ___________________________________ OR

when the following event occurs:____
(Describe event or write "not applicable")

*__Signature of Patient or Patient's Personal Representative:__ ___________________________________

*Date: ___________________________________

Print name of Personal Representative (if applicable): ____

Describe Personal Representative's Relationship or Authority to Act for the Patient (parent, guardian, etc.):

____

* These sections must be completed.