Creighton UNIVERSITY

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL HEALTH INFORMATION

Student Health Education and Compliance(SHEC) must obtain a written authorization from a patient or their personal representative prior to releasing confidential health information, unless a legal exception applies.

PATIENT INFORMATION

I hereby authorize SHEC to release and/or request confidential health information of the patient listed below.

Name:_____
DOB (MM-DD-YYYY):_____ NET ID:_____ Phone: _____
Address: _____

RECIPIENT/SENDER INFORMATION

☐ Exchange Information with CHI Health Student Care Clinic only

☐ Receive Information **FROM** SHEC

☐ Deliver Information **TO** SHEC

Name:_____
Email Address:_____
Address:_____
Phone:_____
Fax:_____

Please send my records by, please circle: Fax Mail I will pick up in person at SHEC Email Verbal/phone conference

Purpose of release, please circle: Treatment/Continuity of Care Accommodations Attendance Personal Use Legal

SPECIFIC TREATMENT PERIODS

Specific treatment date or time period for which the information is requested:

☐ Single treatment date of_____
☐ Period of treatment from_____to_____
☐ Any and all treatment encounters to date.

HEALTH INFORMATION TO BE DISCLOSED

☐ Treatment or Care Summary
☐ Dates of Service (Attendance Only)
☐ Immunizations Reports
☐ Lab/Diagnostic Records
☐ Provider notes

Other_____

This Agreement expires in 180 days unless specified below:
☐ At the end of my education from Creighton
☐ Other: _____

ADDITIONAL AUTHORIZATION REQUIRED

I authorize the release of the following types of records.
☐ Treatment for Alcohol and/or Drug Abuse
☐ HIV/AIDS

NOTE: Patients who believe these record types do not pertain to them may still choose to authorize release to expedite the record release process. If you choose not to authorize, your record must be reviewed in detail to determine if these record types are present. This review and redaction process can take up to 30 business days.

I understand that:

1. I have the right to revoke this authorization at any time by notifying Creighton University Student Health Education in writing. If not revoked earlier, this authorization will expire in one year. Revoking this authorization does not affect disclosures already made by Creighton or disclosures otherwise required by law.
2. I have the right to review my health record before signing this authorization. Creighton's Notice of Privacy Practice explains how to request access to my health record.
3. There may be a fee associated with the copying of records.
4. I am authorizing disclosure of information protected by state law. This information, once disclosed, may be subject to redisclosure by the recipient and no longer be protected by state law.

SIGNATURES

I have read the above and authorize the disclosure of the confidential health information as stated.

Signature of Patient/Personal Representative:	Date:
Print Name of Patient's Personal Representative: (if applicable)	Relationship to Patient

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