

Philadelphia University Student Health Services (PUSHS)
Patient Authorization to Release Protected Health Information (PHI)

If the information includes records or information from another health care provider or entity, that information:
(Check one.) should or should not be released under this Authorization.

Please Note: This Authorization applies ONLY to the information indicated above, and information will be sent ONLY to the above address or fax number. Additional information or disclosure to another person or entity or another address or fax will require another Authorization.

PATIENT ACKNOWLEDGEMENT-PLEASE READ CAREFULLY

Re-disclosure: I understand that when the information is disclosed pursuant to this Authorization to someone who is not required to comply with the federal or state privacy protection requirements, my information may be subject to re-disclosure by the recipient and may no longer be protected.

Revocation: I further understand that I retain the right to revoke this Authorization at any time, if I do so in the manner set forth below. I understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my PHI have already acted in reliance on this Authorization.

In order for my revocation to be effective, it must be in writing. The revocation must include:

- The patient's name, address and identification number, if applicable
- Sufficient information to identify this Authorization including date and recipient of PHI
- The patient's desire to revoke this Authorization
- The intended date of the revocation, if later than the receipt of the revocation, and
- The patient's signature

ALL revocations must be sent in writing to the entity releasing the PHI at the address provided above. A revocation is not effective until the later of the date it is received by the entity or any other date specified in the revocation. The Philadelphia University Student Health Services will accept written revocations of this Authorization, sent to the attention of Student Health Services via:

- Hand Delivery
- Certified US Mail
- Facsimile at 215-951-6867

Inspect and Copy: I understand that I have the right to inspect or copy my PHI to be used or disclosed pursuant to this Authorization, as permitted by law.

Conditioning Treatment: I understand that the Philadelphia University Student Health Services will not condition my treatment, enrollment in a health plan or eligibility for benefits on whether I provide Authorization for a requested use or disclosure.

I AUTHORIZE THE USE AND/OR DISCLOSURE OF MY PHI AS DESCRIBED ABOVE. I HAVE READ THE CONTENT OF THIS AUTHORIZATION, AND I FULLY UNDERSTAND AND ACCEPT ITS TERMS.

Signature of Patient

Date

Witness

Date

The Health Center reserves the right to authenticate patient signature on forms received by fax or mail prior to the release of requested information. Electronic signature is not accepted at this time.

FOR INTERNAL OFFICE USE ONLY Disclosures made in response to Authorization (PHI), (date and recipient) are to be documented in the patients' medical record (PMR).

Revocation Received: _____ Statement and/or information mailed/faxed to parent/student/other: By _____ On: _____
Authorization verified and added to the PMR: By _____ On: _____ Copy of Authorization given to patient, if applicable: By _____ On: _____