Authorization & Fax Transmittal
To Release Personal Health Information

SHaW Medical Records
Fax: 860.486.5300
234 Glenbrook Road. Unit 4011
Email: shaw-medicalrecords@uconn.edu
Phone: 860.486.2985

UCONN
STUDENT HEALTH AND WELLNESS

Patient's Name (Please Print)		
Name (If different) at time of visit(s) or treatment(s):		
Date of Birth	**Peoplesoft ID#**	**Telephone #**

I hereby authorize Student Health and Wellness:

☐ to disclose information from my treatment record to: and/or ☐ to obtain information from:

Name: _____

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

Phone: _____ **Fax:** _____

I authorize the following information to be obtained/disclosed from my treatment record(s):

Dates of treatment: _____

☐ Copy of Medical record

☐ Copy of Mental Health record

☐ Excerpts from record as follows:

☐ Encounter Notes ☐ Athletic Records

☐ X-ray Results ☐ HIV Information ☐ Other(Specify): _____

☐ Lab test results ☐ Itemized Bill ☐ Echocardiogram/EKG

The purpose of this request is for:

☐ Dr./Clinician visit ☐ Insurance claim ☐ Legal matter ☐ Meal Plan Exemption ☐Immunizations ☐ Coordination of Care
☐ Clinical site visit for Allied Health, Nursing, PT & Pharmacy ☐ Other (specify):_____

Method of Disclosure:

☐ Mail ☐ Fax ☐ Verbal ☐ Email ☐ Paper Copies (Pick up:_____)

AUTHORIZATION

I the undersigned, hereby authorize the release of the above personal health information as I have indicated.
I understand that I may revoke this authorization to release information at any time by giving written notice. However, I understand that any information released prior to my revoking this authorization shall not be a breach of my right to confidentiality.
Unless I revoke this authorization prior to such time, this authorization shall expire_____(90 days if left blank.)

MENTAL HEALTH/SUBSTANCE ABUSE/HIV/AIDS: I understand that information to be released or obtained may include mental health information addressed by CGS 52-146(d), substances abuse treatment information in accordance with 42 CFR 2.1-2.67, and

HIV/AIDS-related information addressed by CGS 19a-585(a), except as indicated below.

PROHIBITION ON REDISCLOSURE: This information has been disclosed from records whose confidentiality is protected by Federal and State law. Regulations prohibit making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. We will not include any records from outside agencies unless specifically indicated below.

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I consent to the re-disclosure of information with these conditions:

☐ Include all records from outside agency/providers except _____

√_____
Patient's Signature/Healthcare Representative Date

√ _____
Patient's Name (Printed) People Soft Number

PLEASE NOTE: ***If faxed, the information contained in this facsimile message is privileged and confidential and intended for the use of the addressee listed above. If you are neither the intended recipient or the employee or agent responsible for delivering this information to the intended recipient, you are hereby notified that any disclosure, copying, distribution, or taking any action in reliance on the content of this telecopied information is strictly prohibited. If you have received this copy in error, please immediately notify the sender to arrange for return of the original documents to us.***

Rev. 03/01, 4/02, 3/03, 9/07.9/08(2)(3)12/08/,9/12,6/13, 12/13,3/14, 7/18, 6/19, 8/19,5/20, 7/23