# Authorization & Fax Transmittal
# To Release Personal Health Information

SHaW Medical Records
Fax: 860.486.5300
234 Glenbrook Road. Unit 4011
Email: SHS@uconn.edu
Phone: 860.486.2985
Storrs, CT 06269-4011

UCONN
STUDENT HEALTH AND WELLNESS

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

| **Release My UConn Information To:** | | **Obtain Information From:** | |
|---|---|---|---|
| **I authorize that my UConn SHaW information be disclosed to and used by the individual below.** | | **I authorize information from another healthcare provider/agency/hospital/clinic listed below, be provided to UConn SHaW.** | |
| **Name** | | **Name** | |
| **FAX #** | **Phone#** | **FAX #** | **Phone#** |
| **Address** | | **Address** | |
| **City** | | **City** | |
| **State** | **Zip** | **State** | **Zip** |
| **Method of Disclosure:** ☐ **Mail** ☐ **FAX** ☐ **Verbal** ☐ **Review** ☐ **Email** **Pickup on this date:** | | **Please FAX to: 860-486-5300** **UConn SHaW Clinician who needs information:** | |
| **Comments:** | | | |

**The purpose of this request is for:**

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

**Information to be released please check:**

| | | | |
|---|---|---|---|
| Date(s) of visit(s) or treatment (s): | | | |
| ☐ Copy of entire Primary Care record (will include drug & alcohol, communicable disease information including HIV test results, notes and related information, if any). This does not include Mental Health records unless a release has been signed by the student and is indicated below. | | | |
| ☐ Copy of Mental Health record (this will include drug & alcohol, and HIV related information). | | | |
| ☐ Lab | ☐ X-ray | ☐ Encounter Notes | ☐ HIV Information |
| ☐ BASICS & MAPP | | ☐ Drug and Alcohol Records | |
| ☐ Athletic Records | | ☐ Information for clinical program sites | |
| ☐ Other (Specify) | | | |

**AUTHORIZATION**

I the undersigned, hereby authorize the release of the above personal health information as I have indicated.
I understand that there may be a charge of $0.65 per page depending on the purpose of this request. 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 in accordance with CGS 52-146(d), substances abuse treatment information in accordance with 42 CFR 2.1-2.67, and

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HIV/AIDS-related information in accordance with 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 without 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. Regulations state that any person who violates any provision of this law shall be fined not more than $500 in the case of the first offense and not more than $5,000 in the case of each subsequent offense.

I consent to the re-disclosure of information with these conditions: (PLEASE CHECK ONE)

☐ Include all records from outside agency/providers except _____
☐ Do not include any records from outside agency/provider.

√_____
Patient's Signature/Personal Representative Date

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

If personal representative please note relationship to the patient:

☐Parent ☐Guardian ☐Spouse ☐Domestic Partner ☐Other (please specify) _____

**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.***

**Date work completed_____# Pages _____**

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