The University Of
TAMPA
DICKEY HEALTH AND WELLNESS CENTER

Authorization for Release of Patient Health Information

PATIENT NAME: First and Last **Student ID#:** **DOB:** Month/Day/Year **AGE:**

TELEPHONE#: **Emergency Contact Name:** **Emergency Contact Ph#:**

SECTION A:

The undersigned hereby authorizes and requests the Dickey Health and Wellness Center to:

Release my medical records to my ❑ Health Care Facility or ❑ Previous PCP or ❑ Parent(s) ❑Rapid Trace ❑ Release my current medical status to the athletic department at The University of Tampa. or ❑ The University of Tampa/my professors or ❑ Self.

Complete **SECTION C** for specific information requested.

Enter contact info below for the Health Care Facility or Previous PCP or Parent(s) indicated above.

Full Name(s):_____Address:_____City:_____State:_____Zip:_____

Telephone #: _____ Fax number: _____

OR

SECTION B:

The undersigned hereby authorizes and requests: Name of Health Care Facility or PCP:_____Phone#: _____Fax:_____ **to release medical, alcohol, AND/OR substance abuse information contained in patient's medical records for the purpose of continued care to: Dickey Health and Wellness Center, The University of Tampa**

401 W. Kennedy Blvd., Tampa FL 33606 Phone:

(813) 253-6250– Fax: (813) 258-7413

SECTION C:
Specific information requested to be released (check all that apply):

❑ PAP/Contraception Records	❑ X-ray and Imaging Reports	❑ Immunization Record
❑ Consultation Reports	❑ ER Record	❑ Most Recent History and Physical
❑ Laboratory Results	❑ Entire Record	❑ Progress Notes
❑ Verbal only (please specify)_____		❑ Other_____

I authorize the release of information covering the period(s) of healthcare from: Date(s)to: Date(s) _____

I understand that signing this authorization is voluntary. My treatment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Dickey Health and Wellness Center. I understand that information contained in my medical record may contain HIV/AIDS testing, results, and/or treatment records.

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal confidentially rules. If I have questions about the disclosure of health information, I can contact the Director of Medical Services at (813) 253-6250. The Dickey Health and Wellness Center will respond to your request within 48 to 72 hours from date of receipt.

This authorization will expire: Date_____. If not otherwise specified, this release will expire within 12 months from the date signed.

In what format would you like to receive your records? (choose one):

❑ Paper (please send to the name and address in section A) ❑ Email-secure message using spartan email (**current University of Tampa students only**)

❑ I wish to pick up my records (during the Dickey Health and Wellness business hours)

Date:

Signature of Patient or Guardian **Relation to Patient** Month/Day/Year

Date:

Signature of Office Witness or Notary **Printed Name of Witness** Month/Day/Year