

**Nova Southeastern University Student Medical Center  
Authorization for Use or Disclosure of Information**

If you are an HPD student, what year did you enroll? \_\_\_\_\_ Which program? \_\_\_\_\_

I request and authorize Nova Southeastern University Student Medical Center located at 3200 S. University Drive, Ft. Lauderdale FL 33328, Phone (954) 262-1262, **Fax (954) 262-3815** to:

Release the following information to (Address/City, State, Zip):

\_\_\_\_\_ Phone No.: (     ) \_\_\_\_\_  
\_\_\_\_\_ Fax No.: (     ) \_\_\_\_\_  
\_\_\_\_\_

Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.

\_\_\_\_\_

This protected health information is being used or disclosed for the following purposes: (List specific purposes here, the patient may indicate that the information to be disclosed is "at the patient's request" if the patient does not choose to provide an explanation of the purpose of the request)

Insurance      Attorney      Personal Review      Continued Care by other health care provider  
 School      Disability      Other (please specify): \_\_\_\_\_

I understand and agree that the information I am authorizing to be released may include:

- (1) AIDS/HIV test results, diagnosis, treatment and related information;
- (2) Drug screen results and information about drug and alcohol use and treatment;
- (3) Mental health information, and/or
- (4) Genetics Testing

Unless otherwise requested: \_\_\_\_\_

This authorization shall be in force and effect until: (Please complete one of the following)

Expiration of Authorization Date (Insert Expiration Date): \_\_\_\_\_

OR The happening of the following expiration event: \_\_\_\_\_

I understand that, as set forth in NSU's Notice of Privacy Practice, I have the right to revoke this authorization, in writing, at any time by sending written notification to: Maureen Simunek-Appelt, Nova Southeastern University Health Care Center, 3200 S. University Drive, Ft. Lauderdale, FL 33328. I understand that a revocation is not effective to the extent that the clinic has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that the clinic will not condition my treatment on whether I provide authorization for the requested use or disclosure. I understand that I have the right to

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

I certify that this form has been fully explained to me, that I have read it or had it read to me, and that I understand its contents.

\_\_\_\_\_  
**Signature** of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Print name** of Patient or Personal Representative

\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Description of Personal Representative's Authority

\_\_\_\_\_  
Patient Social Security Number