NSU NOVA SOUTHEASTERN UNIVERSITY

Date Received – Official Use Only

Unicorn Children's Foundation Clinic

Authorization for Use or Disclosure of Protected Health Information (PHI)

Patient Name (Last, First, Middle Initial):		
Patient Address:		
City	State:	Zip Code:
Telephone #:	Date of Birth	

I authorize release/disclosure of the patient's health records and information:

From the health care provider, physician, office, facility as listed below:	**To** the patient, personal representative, health care provider, physician, office, facility as listed below:
Name:	Name:
Address/City/State/Zip:	Address/City/State/Zip:
Telephone #:	Telephone #:
Health Care Provider Fax # (if applicable):	Health Care Provider Fax # (if applicable):
Attention:	Attention:

I authorize release/disclosure of the following health information during the term of this Authorization: (*Check all that applies):*

☐ Entire Medical Record
☐ Specific Date of Service ___/___/___
☐ Specific Date Range ___/___/___ to ___/___/___
☐ Billing Records (Specify date or date range) _____
☐ Records related to a specific injury with the following date (e.g. worker's compensation injury)
☐ Imaging/Radiology Films (Specify date or date range) _____
☐ Hospitalization (H & P, Consult, Tests, Surgical, Discharge Summary)
☐ Test Results (Specify: Lab, X-Ray, EKG, etc.)_____
☐ Therapy Notes (Specify: PT, OT, Speech, etc.) _____
☐ Other _____

The purpose of the disclosure is: (*Check all that applies):*

☐ Continuation of Care
☐ Legal
☐ Personal Reasons (at the request of the individual)
☐ Insurance
☐ Insurance
☐ Other _____

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse. State and federal law protect the following information. If this information applies to you, please indicate if you further authorize the disclosure of the following information, which may be included in the health information listed above.

(The following must be separately initialed by you if applicable to your authorization. Initial all that applies):

☐ STD /HIV/ AIDS	☐ Alcohol, Drug, or Substance Abuse	☐ Mental Health	☐ Genetic Data	☐ Records created by non-NSU providers

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Expiration of Authorization:

This authorization will remain in force and effect under the following conditions: (*check one preference*)

☐ From the date of this Authorization until the following date: ____/_____/_____

☐ Until the happening of the following expiration event: _____

If I do not specify an expiration date or event, then this Authorization will expire ninety (90) days from the date on which I sign the Authorization.

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:

Dr. Roseanne Lesack
Nova Southeastern University
Mailman Segal Center for Human Development
3301 College Avenue
Fort Lauderdale-Davie, Florida 33314

- I understand my revocation will not apply to information already retained, used or disclosed in response to this Authorization.
- 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 Description of Personal Representative's Authority

Official Use Only

Completed by: _____ (Print Full Name) Date completed: _____

Delivery method: ☐ FAXED TO HEALTHCARE PROVIDER ☐ MAILED ☐ IN PERSON ☐ E-MAILED TO THE PATIENT (ADDENDUM COMPLETED)

File in Patient Chart
Date: May 2016 Revision: October 2017

Note: Only in the special circumstance where a Patient requests his/her medical record to be emailed directly to the Patient, the Patient's Personal Representative, or another person designated by the Patient above, then the attached addendum must be completed as well.

Nova Southeastern University (NSU)
Unicorn Children's Foundation Clinic
Addendum to Authorization for E-Mail Communications

E-mail address (please print clearly – one letter per box):

Confirm e-mail address (please print clearly – one letter per box):

I request that the protected health information designated in the attached authorization be communicated via encrypted e-mail communication at the above listed email address, which I have confirmed to be accurate. I acknowledge and understand that e-mail communication may contain my personal and private medical information including, but not limited to, my name, address, date of birth, social security number, types and dates of health care services received, medication, insurance coverage information, and/or test results. I understand that the NSU Health Care Center and its health care providers are not responsible for the security of e-mail communications once they are received and stored at the email address listed above.

I understand that e-mail communications may not be secure, even if encrypted, and that the protected health information could include identifiers that could be intercepted and used maliciously for criminal purposes such as identity theft. I further understand that responses to the e-mail communication may not be encrypted or secure. Additionally, I understand that it is the policy of NSU that it may not exchange clinically-relevant information with patients via email, **except if the Patient or the Patient's Personal Representative requests a copy of the patient's medical record via email, or as specifically permitted by NSU.**

As such, I understand that if the NSU Health Care Center receives an email from a patient that relates to his/her medical care, the NSU Health Care Center is responsible for notifying the patient that other than providing a copy of the requested medical record the NSU Health Care Center does not communicate clinical information by email, and that the patient should call the office to address the matter or make an appointment, as appropriate, or call 911 for any and all emergencies. With these understandings, I authorize NSU to communicate via email communications at the above listed email address.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Description of Personal Representative's Authority

Date: May 2016 File in Patient Chart