Nova Southeastern University (NSU)
Student Counseling
Authorization for Use or Disclosure of Information

Date Received – Official Use Only

Patient Name (last, first, middle initial):_____ Date of Birth:_____
Patient Address:_____ City:_____ State:_____ Zip: Code_____
Telephone No.: ( )

I request and authorize Nova Southeastern University to: *(Check the one that applies)*
☐ Release the following information to: OR ☐ Receive the following information from:

Name of Facility/Person: _____

Address/City, State, Zip: _____

_____

Telephone No.: ( )_____
Healthcare Provider Fax No.: ( )

I authorize the Student Counseling to use or disclose the following health information during the term of this Authorization: (*Check all that apply)*

☐ 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 the apply*

☐ Continued care by other health care provider
☐ Insurance
☐ Attorney
☐ Disability
☐ School
☐ Personal Review
☐ Worker's Compensation Claim Review
☐ Other (please specify) _____

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

(1) HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
(2) Information about Substance (i.e., alcohol or drug) Abuse
(3) Information about Abuse of an Adult
(4) Information about Sexual Assault
(5) Information about Child Abuse and Neglect
(6) Information about a Mental Illness or Developmental Disability
(7) Information about Communicable Diseases
(8) Information about Venereal Disease(s)
(9) Information about Genetic Testing

Effective Date 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: _____

_____

_____

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:

Caitlin Ballback
Nova Southeastern University
Student Medical Center
3200 South 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 Description of Personal Representative's Authority

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Official Use Only

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

Delivery method: ☐ FAXED TO HEALTHCARE PROVIDER ☐ MAILED ☐ IN PERSON

File with record when completed

Form: March 2012