Drew University Health Service
36 Madison Avenue
Madison NJ 07945
Tel: 973-408-3414 Fax: 973-408-3031
Email: health@drew.edu

Patient Name: _____
Date of Birth: _____Drew ID Number _____
Phone: _____
Email: _____
Year last attended Drew_____

Authorization for Release of Protected Health Information

I hereby authorize Drew University Health Service to (choose one):

____**Disclose** my protected health information to: **OR** _____**Obtain** my protected health information from:

Name_____ Phone _____
Street_____
City: _____ State_____ Zip_____ Fax_____

If requesting record disclosure, I prefer my records to be (choose one) _____mailed _____faxed

I understand that this consent shall operate as a complete release of liability to the university and to its employees for the release of the information as specified below.

INFORMATION TO BE RELEASED:

___ Immunizations ___Radiology Report ___Physical ___OB/GYN Report
___ Laboratory Report ___Comprehensive Record (2 years only will be copied unless by special arrangements)
___ Other _____

The following information requires your specific initials and will be released only if it is initialed:

_____*HIV testing* ____*Substance abuse referrals* ____*Mental health referrals*
_____*STD testing* ____*Sexual assault*

PURPOSE OF RELEASE OF INFORMATION:

___ Legal reasons ___Sharing with other health providers ___ Insurance Claims Information
___ Personal Use ___ Worker Compensation ___ Referral
___ Other_____

Note: If you are requesting Drew to provide copies of your medical records to the individual or entity specified above, please explain below why circumstances effectively preclude an in- person review of those records and require production of records. _____
_____

I understand that this authorization will expire 90 days after the date appearing above.

I understand that I may revoke this authorization at any time by notifying Drew University Health Service in writing, and this authorization will cease to be effective on date notified except to the extent action has already been taken in reliance upon this authorization.

I understand that once Drew University Health Service discloses this information it may be re-disclosed by the recipient to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of health information. I am aware that records transmitted via fax or mail may not be secure.

I understand that there may be sensitive information within these records regarding my health.

I have read and understand the terms of this authorization and I have had/taken an opportunity to ask questions about the use and disclosure of my health information. I certify that I am the patient stated above and I hereby knowingly and voluntarily authorize Drew University Health Service to disclose my health information in the manner described above.

Signature:_____Date:_____
Print Name:_____

If requesting Drew University Health Service to disclose your information to you or another party please read the following:

Students Actively Enrolled at Drew University: To request a copy of any part of your medical record you will need to submit page one of this Authorization. Please plan to pick up your medical record from our office.
Former Students: Submit both pages of this Authorization to the Coordinator of Medical Records. With your request include your credit card information or a check made out to Drew University Health Service. Please see the Payment Information below. This fee covers the administrative copying. We will attempt to process your completed request within 10 business days.
Note: All inactive charts are retained for 10 years.

_____ ***I will call the Health Service with my Credit Card information, 973-408-3414.***
Card Holder Signature: _____

We discourage using fax for transmission of Credit Card information since this is not secure. Please send all paper work to the following address: Drew University Health Service
36 Madison Ave
Madison, NJ 07940

For Health Service Use Only:
Processed by: _____Date: _____

NOTES: _____

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Drew University Student Accounts will shred Credit Card Information after processing fee for medical records.

Payment Information: *
A fee of $10.00 is required for copies of your record.
**No charge for Actively Enrolled Students*

Credit Card Information: ___American Express ___Master Card ___Visa
Name on Credit Card: _____
Credit Card Number: _____ CVV# _____
Expiration Date: _____ Today's Date: _____
Total Amount Due: _____