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AUTHORIZATION FOR THE RELEASE OF HEALTH RECORDS

I authorize the release of my health records ***to/from*** _____

to/from _____

Records to be released _____

For the purpose of_____

I understand the following:

- ✓ That my health record(s) will not be released or obtained by Eastern University unless permission is provided for herein as evidenced by the signature on this Authorization for Release of Protected Health Information.
- ✓ That the release of my health record(s) will be for the purpose stated on this form and only those items indicated will be released.
- ✓ That the health record(s) released by the facility/person authorized above may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) its staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the Privacy Rule.
- ✓ That this Authorization is in effect for a period of 90 days from the date of signature, unless a specific timeframe is documented, however, no timeframe specified shall go beyond one year from the date of signature.
- ✓ That I have the right to revoke this Authorization form at any time by sending a written request to the entity where the authorization was provided.
- ✓ That my decision to revoke this Authorization does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke the Authorization.
- ✓ That my decision to revoke the Authorization may result in my insurance company not being able to pay for my medical claim, and I may be liable for payment of the claim.
- ✓ That I am entitled to a copy of this completed Authorization Form.

Printed Name: _____ Birth Date: _____ Student ID: _____

Student Signature: _____Date: _____