# HIPAA Right of Access Form

I, ___________________________, direct my health care and medical services providers to disclose and release my Protected health information described below to:

_____________________________________________ _____________________________

Name of Contact | Relationship

_____________________________ _____________________________

Cell Phone | Home Phone

**Health Information to be disclosed** upon the request of the person named above (check either A or B):

____ **A. Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions).

____ **B. Disclose** my health record as above, **BUT do not disclose** the following (check request):

___ Mental health records ___ Communicable diseases (STI, HIV, etc.)

___ Alcohol/drug abuse & treatment ___ Pregnancy

____ Other (please specify) ____________________________________________________________

______________________________________________________________________________

**I understand** 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.

This authorization shall be effective until (check one):

____ Transfer/Graduation from Eastern University

____ Date or event: ____________________________________________________unless I revoke it.

(NOTE: You may revoke this authorization, in writing, at any time by notifying the Student Health Center.)

**I understand the following:**

- 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 this 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.

_____________________________________________ ________________ ________________

Printed Name | Birth Date | Student ID

______________________________________________________________________ ________________

Signature of the Individual Giving this Authorization | Date

** I decline to release my PHI to anyone at this time. _______________________________

Signature

## Acknowledgment of Receipt Student Health Center HIPAA Disclosure and Notice of Privacy Practices

____ I understand and have been provided with the EU Student Health Center HIPAA Disclosure and Notice of Privacy Practices that provides a more complete description of medical information uses and disclosures.

____ I understand that I have the right to review the notice prior to signing this acknowledgement form.

____ I understand that the Student Health Center (SHC) reserves the right to change their notice and practices. That change will be posted in the office and available on the website.

____ I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that Eastern University is not required to agree to the restrictions requested.

____ I understand that I may revoke this acknowledgement in writing, except to the extent that the SHC has already taken action in the reliance thereon.

____ I understand this will be in effect as long as I am a student at Eastern University.

***OR***

____ I refuse a copy of the SHC HIPAA Disclosure and Notice of Privacy Practices.

_____________________________________________ ______________

Student Signature Date

_____________________________________________ ______________

Printed Name Refused/Initials