ASBURY UNIVERSITY
Academic Excellence & Spiritual Vitality

Patient Authorization to Send or Receive Protected Health Information

I, _____[Print name] _____(DOB), hereby authorize

Asbury University Health Services to send and/or receive Protected Health Information as described below:

I authorize the following person(s) or organization to send/receive the information:

Person/Organization:_____

Street Address:_____

City, State, Zip Code: _____

Description of the information to be *sent/received*:
(Please check all that apply:)

___Discharge Summary
___History and Physical Records
___Progress Notes
___Consultation Reports
___Complete Medical Record
___Immunization Record
___Reports of Lab Tests
___Reports of Imaging
___Emergency Room Records
___Operative Reports
___Physical Therapy Notes
___Other: _____

Dates of treatment to be released: _____

Purpose(s) of the information: __ Continuity of Care __ University Requirement

__Other: _____

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment, and/or HIV-related conditions

Re-Disclosure: I understand that the information used an/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially redisclose it.

Revocation: The patient has a right to revoke this authorization in writing, except to the extent that action has already been taken on this authorization. In order for the revocation of this authorization to be effective, Asbury University Health Services must receive the revocation in writing. The revocation must include the patient's desire to revoke this authorization and:

- The patient's name and address,
- The effective date of this authorization,
- The recipients of the Protected Health Information according to this authorization,
- The date of the revocation, and
- The patient's signature.

ALL revocations must be sent to Asbury University Health Service to the attention of the Privacy Officer, Heidi Sunny, R.N., either in person, by mail or fax (859-858-0003) and are not effective until received by the Privacy Officer.

Expiration: This authorization shall expire in 30 days. After this, Asbury University Health Services can no longer use or disclose the patient's Protected Health Information without first obtaining a new authorization form.

This Authorization is binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in Asbury Health Services Notice of Privacy Practices.

I fully understand and accept the terms of this authorization.

_____ _____ _____

Patient's Signature Date Witness' Signature