

Student Name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ UAF ID#: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Today's Date: \_\_\_\_\_

**I HEREBY AUTHORIZE THE DISCLOSURE AND USE OF MY HEALTH INFORMATION:** [CHECK AS APPROPRIATE]

From  To  Both (Two-way)

**UAF Student Health and Counseling Center**

1788 Yukon Drive  
Fairbanks AK 99775  
Phone: 907-474-7043  
Fax: 907-474-5777

From  To  Both (Two-way)

Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

**DATES OF RECORDS/INFORMATION TO BE RELEASED** From: \_\_\_\_\_ To: \_\_\_\_\_ or All: \_\_\_\_\_

**TYPES OF RECORDS/INFORMATION**

[Check as appropriate]

- All medical records
- Immunization record(s)
- Lab result(s)
- Psychological testing reports
- X-ray or other diagnostic test reports
- Other (please specify) \_\_\_\_\_

**The following items must be initialed by you if you desire these records to be released:**

Sexually transmitted diseases: \_\_\_\_\_  
Genetic testing: \_\_\_\_\_  
HIV/AIDS: \_\_\_\_\_  
Substance or alcohol use/abuse: \_\_\_\_\_  
Counseling visit notes (psychotherapy notes-release  
*may require consult with counselor*): \_\_\_\_\_

**If our records include records or information from another health care provider or entity, that information:**

[Check one]  should or  should not be released under this Authorization.

**METHOD OF DISCLOSURE:** Mail\_\_\_\_ Fax\_\_\_\_ In person\_\_\_\_ Verbal\_\_\_\_

**PURPOSE OF DISCLOSURE (optional):** Personal Use\_\_\_\_ Health care\_\_\_\_ Legal\_\_\_\_ Parent/Guardian\_\_\_\_ Insurance\_\_\_\_ Other\_\_\_\_

**EXPIRATION OF AUTHORIZATION:**

This authorization will expire in **one year** unless otherwise noted here: \_\_\_\_\_

**Re-disclosure:** I understand that when the information is disclosed pursuant to this Authorization to someone who is not required to comply with the federal or state privacy protection requirements, it may be subject to re-disclosure by the recipient and may no longer be protected.

**Revocation:** I understand that I may revoke this Authorization at any time by writing to the address above. A request to revoke my authorization will not apply to the extent that SHCC has taken action in reliance upon this authorization.

**Conditioning of Eligibility:** SHCC will not condition treatment, payment, and enrollment or benefit eligibility on my signing this document.

\_\_\_\_\_  
Signature of student or other authorized person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of other authorized person (if used)