University of New Hampshire
The Wellness Center

Policy and Procedure Manual
Form Number: 201.1

Authorization for Release of Health Information

Step 1 *Please fill in your demographic information*	**Information about you:** Patient Name: _____ Date of Birth: _____ Address: _____ Phone Number: _____ Student ID: _____
Step 2 *Provide us with as much information as possible*	**I hereby authorize:** University of New Hampshire Wellness Center 4 Pettee Brook Lane Durham, NH 03824 Phone: (603) 862-9355 Fax: (603) 862-4259 **CIRCLE ONE** **To release my records to obtain my records from:** _____ _____ _____ **Type of Disclosure (circle one):** Verbal Fax Paper Copy *We cannot send medical records via email - our system is not secure for transmitting PHI.*
Step 3 *Please read carefully and authorize the records to be released*	If my initials appear here: _____, I authorize the release of ALL RECORDS, which include office notes, lab reports, diagnostic imaging, problem lists, medication lists, and Immunization records. **OR** Release only the following: _____ Specific Dates: _____
Step 4 *Please read thoroughly, sign, and date*	I understand that if my medical record contains information regarding ***drug and/or alcohol abuse, psychiatric treatment, HIV/AIDS testing, and/or treatment, Nutrition/Dietary*** I agree to the release of those sensitive records by signing below. _____ _____ Patient Signature/Legal Guardian Date
Step 5 *Please read thoroughly, sign, and date*	I have carefully read and understand the above statement, and so herein expressly and voluntarily consent to disclose the above information about or medical records of my condition to those persons or agencies named above. I hereby release the above-named physician, covering physicians, and facility from any liability arising from releasing my medical records. By signing, I understand that requests for copies of health records are subject to reproduction fees following state & federal regulations. This authorization will expire 12 months from the date of signature. _____ _____ Patient Signature/Legal Guardian Date

Completed forms can be faxed, mailed, or emailed to *health@unh.edu*