University of New Hampshire
Health & Wellness

Form #201.1

AUTHORIZATION TO RELEASE OR REQUEST HEALTH INFORMATION

Health Records Department
603-862-1987/Fax 603-862-4259

4 Pettee Brook Lane
Durham, NH 03824-3577

Patient's name:_____ Date of birth:_____

Address:_____

Patient's Student ID #:_____ Phone:_____

Permission is hereby given for UNH Health & Wellness to release/request the following information from the health record: Check one: □RELEASE TO □ REQUEST FROM

Name:_____ Phone_____

Street:_____ Fax _____

City:_____State_____ Zip_____

Information and dates to be disclosed: From (date)_____To (date)_____ ***Note**: Dates can not be in the future. The date of signature below must be the same as or later than the date of information to be released.

☐Permission for coordination of services from UNH Psychological and Counseling Services
☐Physician/nursing notes ☐X-ray reports ☐History & physical exam ☐Immunization
☐Laboratory tests ☐Complete Health Record ☐Other: _____

PURPOSE FOR RELEASE OF INFORMATION:_____
(Physician, Lawyer, Insurance, Other)

SPECIFIC CONSENT IS REQUIRED TO RELEASE THIS INFORMATION:
(Please sign beside each item you wish us to disclose)

Sexual assault: _____ HIV/AIDS: _____
Mental Health: _____ HIV testing results: _____
Drug/Alcohol: _____ Sexually Transmitted Disease: _____
Other: _____ Genetic Testing: _____

THIS AUTHORIZATION IS VALID FOR 90 DAYS

I understand that I may revoke this consent in writing at any time, except to the extent that action has already been taken in response to this authorization. I also release UNH Health & Wellness from any liability or legal responsibility in connection with the release of the above information. I understand the information disclosed pursuant to this authorization is subject to re-disclosure by the recipient (other than UNH Health & Wellness), which would be beyond the control of UNH Health & Wellness, and may no longer be protected by federal law.

I ACCEPT THE RISKS AND POTENTIAL CONSEQUENCES OF FAXING HEALTH INFORMATION ☐

TYPE OF REQUEST: ☐Mail directly to UNH Health & Wellness, Attention Health Records
☐For pickup ☐Mail to patient ☐Mail to addressee ☐Verbal ☐Other

_____ _____ _____
Patient Signature Date Witness Signature

UNH Health & Wellness does not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization or not.

(Sept2013) *Date Received*_____ *Health Record #*_____