BOISE STATE UNIVERSITY
HEALTH SERVICES

Authorization to Request or Disclose Protected Health Information

Full Name: _____ Date of Birth: _____
Previous Name (if applicable): _____ Phone Number: _____
University ID: _____ Email Address: _____

Requested Records

☐TO ☐FROM
☐Self ☐ Parents ☐Facility/School/Employer
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____
Email: _____

☐TO ☐FROM
Boise State University Health Services
Attn: Medical Records
1910 W. University Dr, Norco Building
Boise, ID 83706-1351
Phone: (208) 426-4385 Fax: (208) 426-4059
Email: medicalrecords@boisestate.edu

MEDICAL

☐ALL Medical Records (Last 2 years of services)
☐ONLY Health Information Specified Below
- ☐Chart Notes pertaining to: _____
- ☐Immunization Records and TB Test
- ☐Lab/Pathology/Diagnostic Results
- ☐Sexual Health (Gyn, STI Tests and Treatment)
- ☐Medical Mental Health Evaluation, Psychiatry and Treatment
- ☐Billing Receipts and Statements
- ☐Other: _____

COUNSELING

☐Progress Notes
☐Summary Letter
☐Testing Summary
☐AODA Information
☐Other: _____
☐Communication with providers about **MEDICAL** information marked on the left
☐Communication with providers about **COUNSELING** information marked above

If you need more than 2 years of records, please explain here: _____

_____

This authorization is valid until date specified to the right or 1 year unless revoked in writing. ☐ Other Date of Expiration: _____

This information for which I am authorizing disclosure will be used for the following purpose(s):

☐My Personal Records ☐Continuation of Care ☐Billing/Payment ☐Other (please describe): _____

My Rights I understand that when I revoke this authorization, it is not effective to the extent that UHS has already relied on the use or disclosure of the protected health information. I understand the protected health information released pursuant to this authorization might be re-disclosed by the party who receives that information and may no longer be protected by federal or state law. UHS will not base my treatment or payment on whether I provide an authorization for the requested use or disclosure, unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party. I understand that I have a right to refuse to sign this authorization. To revoke this authorization, please submit a request in writing to the UHS privacy officer. Once this information is release pursuant to this authorization, it may be re-released by the recipient without knowledge or consent of Health Services or by the patient. If you have any questions concerning this form call (208) 426-1459.

Disclaimer and Signature *HIPAA gives you the right to request a copy of all your medical records. Health Services acknowledges and supports your right to have access to your medical records. Health Services will provide a complete copy of your medical records to you at **no charge for the first request**. For every request thereafter, you will be charged $25.00 for the first 20 pages and $0.15 for each additional page in excess of 20 pages. Payment for records will be required **before** you will receive your requested records.*

I would prefer my records to be released via: ☐ Mail ☐ Fax ☐ Patient Pick-Up ☐ Patient Portal

Specific Authorization: I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have indicated otherwise.

Signature: _____ **Date:** _____

FOR OFFICE USE ONLY

_____ _____ Records were: ☐Mailed ☐Faxed ☐Patient Pick-up ☐Other: _____
Date Completed Completed By (print name)