UNIVERSITY OF DELAWARE
HEALTH

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:	Date of Birth:

I request and authorize the University of Delaware health care providers checked below to disclose medical information about me as specified on this Authorization form:

[ ] Physical Therapy Clinic
[ ] Nurse Managed Primary Care Center
[X] Nutrition Clinic
[ ] Speech-Language-Hearing Clinic
[ ] Emergency Care Unit
[ ] Student Health Services

I request and authorize the medical information to be disclosed to the following individual or entity: *[Provide the name, address, and telephone or email address of the individual or entity to receive the protected health information (the "Recipient").] Provider Name:* _____
Street Address: _____
City, State, Zip: _____
Phone: (_____)-_____ - _____; Fax: (_____)-_____ - _____

I request and authorize the following medical information about me to be disclosed to the Recipient: *[Check all that applies and provide additional detail as may be indicated and required.]*

[ ] My entire medical record of each selected University of Delaware health care provider, including information including the following: *[Initial **only** the categories of information that you want to be included in the disclosure.]*

_____Mental health treatment records
_____Psychotherapy notes
_____Communicable diseases (e.g, HIV/AIDS)
_____Substance use disorder
_____Other *[Please describe:]*

[ ] Only certain parts of my medical record as follows: *[Describe what parts of the record you want to be disclosed.]*

This Authorization to disclose my medical information is being made at my direction.

This Authorization to disclose my medical information shall expire on (i) the provision of the information to the Recipient I have identified, or (ii) in the case of ongoing treatment, the date on which this Authorization is no longer effective under applicable law.

* I can revoke this Authorization at any time unless the above identified health care providers have taken action in reliance on it. To revoke the Authorization, submit a written request to the identified health care providers.
* The health care provider(s) cannot condition my treatment on the execution of this Authorization.
* Information disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient and with certain exceptions may no longer be protected by federal or state law.
* I have the right to receive a copy of this Authorization upon request.

I acknowledge that I have fully read this form and that a copy of this form shall be as valid as the original.

_____ _____
Signature of the Patient or Personal Representative Authorized by Law Date