PURDUE UNIVERSITY
AUTHORIZATION FOR USE, DISCLOSURE OR RELEASE OF PROTECTED HEALTH INFORMATION AND MEDICAL RECORDS

Complete all demographic information: DOB, Address, and Phone number. DocuSign will auto populate patient name.

...nd/or release by Purdue University Student Health Center and its employees, of ...er, or other protected health information as described below:

Individual's Name: ______________________ Date of Birth: ______________

Address ____
(street) (city) (state) (zip)

I.D.#: ___If known, provide PUID______________ Phone #: ______________

Please identify who is to receive the medical records or other medical information:
State name or facility who will receive your information. Can state more than 1 name, if at the same location___________
(name) (fax, if available)

____
(street) (city) (state) (zip)

Please describe specifically what medical records or other health information may be used or released:
State exactly what records you'd like to release. "All records" is acceptable.

Check "No" box if you'd like to prevent the individual or facility listed above from receiving substance abuse or mental health records.

Unless the "No" box is ... ...hiatric, mental health, and drug and alcohol abuse treatment information, if ... including information protected by I.C. 16-39-1-9, I.C. 16-39-2-1 through 16-39-4-2 and I.C. 16-41-8-1. This release permits re-disclosure in accordance with 42 C.F.R., Part 2, which is a federal regulation governing release and use of medical information pertaining to treatment for alcohol or drug abuse. No

Unless the "No" box is marked, the Authorizati... ...able diseases, including human immunodeficiency virus (HIV), and AIDS relat... ...syndrome (AIDS), if contained in said medical record. No

Check "No" box if you'd like to prevent the individual or facility listed above from receiving STI, HIV, or communicable disease information.

I understand that upon release and disclosure of... ...ecords and information may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

I understand that Purdue University will not deny treatment, payment, enrollment or eligibility for benefits based upon whether I sign this authorization. I also understand that an authorization may be necessary in order to process any request I have made for a release of medical records or other medical information. I may inspect or copy any information used or disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by mailing or delivering a written revocation to the Purdue University Student Health Center. The revocation will be effective upon receipt by the University, except to the extent that the University has taken action in reliance on this authorization. I further understand that, this authorization will expire as follows: (1) sixty (60) days from the Signature Date for all records except mental health records, and (2) one hundred eighty (180) days from the Signature Date for mental he... ...t expiration date or event here: ______________________. A... ...ion will no longer be effective, and no further information will be furnished pursuant to it.

Add expiration date. If left blank, authorization will expire 60 days from the date signed.

I understand that there may be a ... ...y Purdue University in preparing and delivering the information requested in this authorization, in accordance with ... Indiana statutes and Purdue policies.

DocuSign will auto populate patient name and date. Click the sign arrow to complete the form and "Finish" to submit.

Signed ______________________________
Patient

______________________________ Date______________
Printed name