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

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. Unless the "No" box is increasing and alcohol abus records you'd like to release. "All records" is acceptable. Individual or facility listed above from receiving substance abuse or mental health records you'd like to freewent the individual or facility listed above from receiving substance abuse or mental health is and or and alcohol abus. No Unless the "No" box is individual or facility listed above from receiving substance abuse or mental health instruction accordance with 42 C. F. R., Part 2, which a federal regulation governing release and use of medical information pertaining to treatment for alcohol or drag abuse. No who how is match, the Athorizati Check "No" box if you'd like to prevent the information. I also understand that an authorization information may be subject to re-disclosure by the recipient and may no tonger portected by ICL 16-39-1-9. ICL (abuse), if containe receiving substance abuse and disclosure of norger portected by rederal privacy regulations. Indicases, including human state acond is subhorization. I may inspect or copy any informa	Complete all demographic information: DOB, Address, and Phone number. DocuSign will auto populate patient name. Individual's Name:	nd/or release by Purdue University <u>Studen</u> ber, or other protected health information	as described below:	loyees, of	
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Printed name