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UNC PEMBROKE | STUDENT HEALTH SERVICES
DIVISION OF STUDENT AFFAIRS

Phone: 910.521.6219
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Authorization for Release of Medical Information

Patient Name (Last, First) Date of Birth UNCP Student ID

I authorize UNCP Student Health Services to:

☐ **Release information to:** ☐ **Obtain my information from:** ☐ **Verbally communicate information with:**

Name/Organization

Address

City/State/Zip Code

Telephone Fax

Please release or send the following information from my health record: (Check all that apply)

- ☐ All Medical Records
- ☐ Progress/Office Notes
- ☐ ER Records
- ☐ Lab Results
- ☐ X-Ray Reports
- ☐ Medication/Prescription Records
- ☐ Allergy Records
- ☐ Women's Health (notes, pap, lab)
- ☐ Other:_____

Specify Date (s) of Service/Treatment:

Purpose of Disclosure:

- ☐ Continuation of Care/Treatment
- ☐ Personal Use
- ☐ Employment
- ☐ Insurance
- ☐ Academic Coordination
- ☐ Other:

This information may be communicated through written, oral, or electronic means. I understand that use of a fax machine to transmit information could result in loss of confidentiality of this records/medical information. I am willing to accept this risk.

All information released will be held strictly confidential consistent with the UNCP Student Health Services Policy and cannot be released without my written consent, except under very limited circumstances. I understand that this release is valid for a period of 1 year and is subject to revocation at any time by me, except to the extent action has already begun in reliance on this authorization.

Any re-disclosure of this medical information by a recipient other than the patient's prior written consent is prohibited.

Signature of Patient or Legal Representative Date

UNCP Student Health Services Witness Date