**The University of St. Francis**

**Health Services**

**500 Wilcox St., Joliet, IL. 60435**

**HIPAA AUTHORIZATION FORM**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, whose date of birth is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize **University of St Francis-Wellness Center (Health Records)** to submit a copy of my medical and/or immunization records to:

Contact Person:

Phone: ( )

Fax: ( )

**Description of Information to be Disclosed**

(Student should initial each item to be disclosed.)

\_\_\_\_ Immunization Health Records

\_\_\_\_ Complete Health Record

**Purpose**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Revocation**

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to **Dr. MaryAnn Andrade-Bekker Counseling and Health Services** at the above address. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

**Expiration**

Unless sooner revoked, this authorization expires on **12 / 31 /2021.**

**Conditions**

I understand that failure to sign this authorization may have the following consequences: **The USF Wellness Center will not release medical and/or immunization records without the Student’s signature.**

**Re-disclosure**

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

By I understand the above information and request a copy of this authorization for my records.

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Signature of Student Date

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\* Signature of Parent, Guardian or Personal Representative Date

\*If you are signing as a personal representative of an individual, please describe your authority to act for this individual.

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\_\_\_\_\_\_ **Wellness Center Staff**: Check here if Student refuses/rescinds their consent to sign HIPAA Authorization Form.

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Staff Signature Date

Wellness Center-Health Records

University of St. Francis