One Year Release Cover Sheet

The attached one year authorization to release health information entitles the named person:

- to request a copy of medical records after a patient visit or periodically throughout the year
- to receive information over the phone regarding a prior visit by the patient
- to consult with provider(s) regarding a visit by the patient
- to request a copy of the walkout statement for insurance filing purposes after a patient visit

Medical records will not be automatically released upon a visit, nor will the Student Health Center automatically notify the named person of a visit by the patient.

Patients will be provided with a walkout statement for insurance filing purposes when they check out after their visits. A copy of this statement may be requested after the visit and according to the terms of the attached agreement.

The release is valid for only one year, unless a shorter amount of time is specified. Periods over one year are not permissible. A new release must be signed each year.

The patient may revoke or limit this authorization at any time by written notice to the Supervisor of the Medical Records Department.

For patients under 18 years of age, a parent or guardian may sign the release but the release will expire upon the patient reaching majority age.

Student Health Center
University of North Carolina at Charlotte
9201 University City Blvd., Charlotte, NC 28223
(704) 687-7400 fax: (704) 687-1796
Attention: Medical Records

ONE YEAR AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's name _____Date of birth _____

ID number _____ Phone number _____

I authorize the UNC Charlotte Student Health Center (SHC) to: (check all that apply)

____ Release Information to: _____ Obtain Information from: _____ Verbally Communicate Information to:

Name/Organization _____

Address _____

Phone number _____

Patient: ____ Pick-up ____ Mail to Name/Organization ____ Fax:_____
Fax number of Name/Organization

I authorize the following information to be released:

____ Complete SHC health records

____ Women's Health (Pap, Pelvic, Lab)

____ Lab

____ X-ray

____ Other or related to particular problem _____

____ Immunizations, including immunization records from other providers

Limitations to the above release:

Limit the above release to the following treatment dates: _____

I understand I may refuse to sign this Authorization. The Student Health Center will not condition my treatment, any payment, or eligibility for benefits on receiving my signature on this Authorization.

I understand that my information may be redisclosed by the authorized person/organization receiving the information and, at that point, the information may no longer be protected under the terms of this agreement.

I may revoke this Authorization at any time by providing a written notice to the Student Health Center, Medical Records Supervisor. The revocation will not apply to information that has already been released in response to this Authorization.

If the patient is under 18 years of age, this release may be signed by a parent/guardian but will expire upon patient reaching majority age (please specify date below).

This authorization expires in one year or (specify date **<u>if less than one year</u>**) _____

I have read and understand the information in this Authorization form:

Signature: _____ Date _____

_____
If other than patient, relationship to patient