Health and Wellness Center:
36 University Drive
Bethlehem, PA 18015
Telephone: 610-758-3870
inluhc@lehigh.edu Fax:610-758-3870

Authorization for Disclosure & Use of Protected Health Information

Name: _____ Date of Birth: _____LIN: _____

Address: _____ Current Phone Number: _____

_____ Email Address: _____

I authorize the Health and Wellness Center to: **( )** Disclose Treatment Records to: **( )** Obtain Treatment Records from:

and by the method of: **( ) USPS Mail** **( ) Fax** **( ) Phone** **( ) Email**

Name/Institution: _____

Address:_____

_____

Telephone: _____Fax:_____

Email: _____

Lehigh Entity (select all applicable below)

( ) CARE Team **( ) Student Affairs**

( ) Sodexo Dietician **( ) Sports Medicine**

( ) University Counseling & Psychological Services

Other:_____

The information released will cover time period from: (MM/DD/YYYY)_____to_____

The specific information to be disclosed/obtained is confined to the following (select all that apply):

Progress Notes/Visit Records **( )** Clinical Evaluations **( )** Treatment **( )** Medications Administered/Prescribed **( )**

Immunizations **( )** TB Test (PPD, QuantiFERON Gold Test, related treatment **( )** Laboratory/Pathology Report **( )**

Radiology (X-Ray, CT, MRI) **( )** Cardiology Report (EKG, ECG) **( )** Gynecological Treatment Records **( )**

Other (please specify): _____

Please specify the purpose of this request (select all that apply):

Disclosure of clinical information to/from another Healthcare Provider for purposes of: Coordination of care **( )**

Personal use by Patient **( )** **( )** Other (please specify): _____

Patient Must Read: I understand that my medical record may contain sensitive information regarding alcohol/drug abuse and/or dependence, mental health treatment, treatment of sexually transmitted infection and/or disease (including HIV/AIDS). This information will **not** be disclosed unless I specify that the information may be disclosed by **signing my full name** if I am authorizing LU HWC to release info related to evaluation, testing, diagnosis, and/or treatment for any of the following conditions:

_____Alcohol/Drug Abuse and/or Dependence

_____STIs/STDs Treatment

_____Mental Health Treatment

I understand that this consent is valid for 90 days from the date of signature unless otherwise specified. I understand I have the right to inspect and/or obtain a copy of the information prior to disclosure. I understand that I may revoke this consent at any time by giving written notice to the Lehigh University Health & Wellness Center. I hereby release Lehigh University, its employees, and agents from any and all legal liability which may arise from the disclosure of this information and waive all claims I have which may arise such disclosure. Expiration of authorization (90 days from the date of the signature unless otherwise specified) MM_____/DD_____/YYYY_____

I understand that there may be fees associated with the copying of requested health information plus postage if requesting to have copies of medical records mailed.

The Lehigh University Health & Wellness Center will process your request for health information within 10 days of receiving this form. We appreciate your patience while we process your request.

_____

Signature of patient or Authorized Legal Guardian Date (MM/DD/YYYY